```
                                       POSITIONS
             NAME                TYPE  LENGTH BEG  END                          CONTENTS
   ------------------------      ----  ------ ---------   ----------------------------------------------------------

****  FI Outpatient Claim        REC    VAR               Fiscal intermediary Outpatient Encrypted Standard
      Record - Encrypted                                  View for version I of the NCH.
      Standard View
                                                          The Encrypted Standard View supports the users
                                                          of CMS data and provides the data in "text"
                                                          ready format for easy conversion to ASCII text
                                                          files. This file is also specifically processed
                                                          to perform CMS standard encryption processes for
                                                          identifiable and personal health information
                                                          data fields.

****  FI Outpatient Claim        GROUP  329    1   329    Fixed portion of the fiscal intermediary
      Fixed Group -                                       claim record for the Encrypted Standard View
      Encrypted Standard                                  of the Outpatient version I NCH Nearline File.
      View

  1.  Record Length Count        NUM     5     1    5     The length of the claim record.

                                                          5 DIGITS UNSIGNED

  2.  Record Number              NUM     9     6   14     A sequentially assigned number for the claims included
                                                          in the file. This number allows the user to link all of
                                                          the records associated with one claim.

  3.  Record Type                NUM     2    15   16     Type of Record.

                                                          CODES:
                                                          00 = Fixed/Main Group
                                                          01 = Carrier Line Group
                                                          02 = Claim Demonstration ID Group
                                                          03 = Claim Diagnosis Group
                                                          04 = Claim Health PlanID Group
                                                          05 = Claim Occurrence Span Group
                                                          06 = Claim Procedure Group
                                                          07 = Claim Related Condition Group
                                                          08 = Claim Related Occurrence Group
                                                          09 = Claim Value Group
                                                          10 = MCO Period Group
                                                          11 = NCH Edit Group
                                                          12 = NCH Patch Group
                                                          13 = DMERC Line Group
                                                          14 = Revenue Center Group

  4.  Claim Sequence Number      NUM     3    17   19     A counter for records that consist of trailer
                                                          information, such as claim line and revenue center data,
                                                          which can occur multiple times for one claim.

  5.  NCH Claim Type Code        CHAR    2    20   21     The code used to identify the type of claim record being
                                                          processed in NCH.

                                                          NOTE1:  During the Version H conversion this field was
                                                                  populated with data through-out history (back to
```

service year 1991).

                                           POSITIONS
                    NAME   TYPE LENGTH BEG   END   CONTENTS
        ------------------------- ---- ------ --------- --
                                                                NOTE2:   During the Version I conversion this field was
                                                                         expanded to include inpatient 'full' encounter
                                                                         claims (for service dates after 6/30/97).
                                                                         Placeholders for Physician and Outpatient encounters
                                                                         (available in NMUD) have also been added.

                                                                DB2 ALIAS: NCH_CLM_TYPE_CD
                                                                SAS ALIAS: CLM_TYPE
                                                                STANDARD ALIAS: UTLOUTPI_NCH_CLM_TYPE_CD
                                                                SYSTEM ALIAS: LTTYPE
                                                                TITLE ALIAS: CLAIM_TYPE

                                                                DERIVATION:
                                                                FFS CLAIM TYPE CODES DERIVED FROM:
                                                                  NCH CLM_NEAR_LINE_RIC_CD
                                                                  NCH PMT_EDIT_RIC_CD
                                                                  NCH CLM_TRANS_CD
                                                                  NCH PRVDR_NUM

                                                                INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                                  (Pre-HDC processing -- AVAILABLE IN NCH)
                                                                  CLM_MCO_PD_SW
                                                                  CLM_RLT_COND_CD
                                                                  MCO_CNTRCT_NUM
                                                                  MCO_OPTN_CD
                                                                  MCO_PRD_EFCTV_DT
                                                                  MCO_PRD_TRMNTN_DT

                                                                INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                                  (HDC processing -- AVAILABLE IN NMUD)
                                                                  FI_NUM

                                                                INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
                                                                FROM: (HDC processing -- AVAILABLE IN NMUD)
                                                                  FI_NUM
                                                                  CLM_FAC_TYPE_CD
                                                                  CLM_SRVC_CLSFCTN_TYPE_CD
                                                                  CLM_FREQ_CD
                                                                NOTE: From 7/1/97 to the start of HDC processing(?),
                                                                abbreviated inpatient encounter claims are not
                                                                available in NCH or NMUD.

                                                                PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                                  (AVAILABLE IN NMUD)
                                                                  CARR_NUM
                                                                  CLM_DEMO_ID_NUM
                                                                OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                                  (AVAILABLE IN NMUD)
                                                                  FI_NUM

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

                                POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
     -------------------------- ---- ------ --------- ---

                                                   CLM_FAC_TYPE_CD
                                                   CLM_SRVC_CLSFCTN_TYPE_CD
                                                   CLM_FREQ_CD

                                                   DERIVATION RULES:

                                                   SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
                                                   FOLLOWING CONDITIONS ARE MET:
                                                   1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
                                                   2.   PMT_EDIT_RIC_CD EQUAL 'F'
                                                   3.   CLM_TRANS_CD EQUAL '5'

                                                   SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
                                                   WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                   1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                   2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                   3.   CLM_TRANS_CD EQUAL '0' OR '4'
                                                   4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
                                                        OR 'Z'

                                                   SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
                                                   WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                   1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                   2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                   3.   CLM_TRANS_CD EQUAL '0' OR '4'
                                                   4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
                                                        OR 'Z'

                                                   SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
                                                   WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                   1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                                                   2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                                   3.   CLM_TRANS_CD EQUAL '6'

                                                   SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
                                                   ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                                                   THE FOLLOWING CONDITIONS ARE MET:
                                                   1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                                                   2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                                   3.   CLM_TRANS_CD EQUAL '6'
                                                   4.   FI_NUM = 80881

                                                   SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
                                                   ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
                                                   1.   FI_NUM = 80881
                                                   2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
                                                        CLSFCTN_TYPE_CD = '2', '3' OR '4' &
                                                        CLM_FREQ_CD = 'Z', 'Y' OR 'X'

```
                                        SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
                                        WHERE THE FOLLOWING CONDITIONS ARE MET:
                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                        2.   PMT_EDIT_RIC_CD EQUAL 'I'
                                        3.   CLM_TRANS_CD EQUAL 'H'
```

```
                                 POSITIONS
            NAME              TYPE  LENGTH BEG  END                          CONTENTS
---------------------------   ----  ------ ---------  ------------------------------------------------------------
```

```
                                        SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
                                        WHERE THE FOLLOWING CONDITIONS ARE MET:
                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                        2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                        3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

                                        SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                                        CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
                                        12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
                                        1.   CLM_MCO_PD_SW = '1'
                                        2.   CLM_RLT_COND_CD = '04'
                                        3.   MCO_CNTRCT_NUM
                                             MCO_OPTN_CD = 'C'
                                             CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
                                             MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
                                             ENROLLMENT PERIODS

                                        SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                                        CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
                                        FOLLOWING CONDITIONS ARE MET:
                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                        2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                        3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'
                                        4.   FI_NUM = 80881

                                        SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
                                        ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                                        THE FOLLOWING CONDITIONS ARE MET:
                                        1.   FI_NUM = 80881 AND
                                        2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
                                             TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

                                        SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
                                        WHERE THE FOLLOWING CONDITIONS ARE MET:
                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                                        2.   HCPCS_CD not on DMEPOS table

                                        SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
                                        WHERE THE FOLLOWING CONDITIONS ARE MET:
                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                                        2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                               more line item(s) match the HCPCS on the
                                               DMEPOS table).

                                        SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
```

```
                                                EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
                                                CONDITIONS ARE MET:
                                                1.   CARR_NUM = 80882 AND
                                                2.   CLM_DEMO_ID_NUM = 38

                                                SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
                                                   CLAIM)
                                                WHERE THE FOLLOWING CONDITIONS ARE MET:
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                   POSITIONS
                NAME              TYPE  LENGTH BEG  END                        CONTENTS
   --------------------------     ----  ------ ---------   ------------------------------------------------------------
```
```
                                                1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                                2.   HCPCS_CD not on DMEPOS table

                                                SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
                                                WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                                2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                                       more line item(s) match the HCPCS on the
                                                       DMEPOS table).

                                                CODES:
                                                  REFER TO: NCH_CLM_TYPE_TB
                                                            IN THE CODES APPENDIX

                                                SOURCE:
                                                NCH
```

```
   6. Beneficiary Birth Date       NUM      8    22   29   The beneficiary's date of birth.

                                                For the ENCRYPTED Standard View of the
                                                Outpatient files, the beneficiary's
                                                date of birth (age) is coded as a range.

                                                8 DIGITS UNSIGNED

                                                DB2 ALIAS: BENE_BIRTH_DT
                                                SAS ALIAS: BENE_DOB
                                                STANDARD ALIAS: BENE_BIRTH_DT
                                                TITLE ALIAS: BENE_BIRTH_DATE

                                                EDIT-RULES FOR ENCRYPTED DATA:
                                                0000000R
                                                WHERE R HAS ONE OF THE FOLLOWING VALUES.
                                                0 = Unknown
                                                1 = <65
                                                2 = 65 Thru 69
                                                3 = 70 Thru 74
                                                4 = 75 Thru 79
                                                5 = 80 Thru 84
                                                6 = >84

                                                SOURCE:
                                                CWF
```

```
     7. Beneficiary Identification   CHAR    2   30  31  The code identifying the type of relationship between an
        Code                                             individual and a primary Social Security Administration
                                                         (SSA) beneficiary or a primary Railroad Board (RRB)
                                                         beneficiary.
```

```
                                       POSITIONS
              NAME             TYPE   LENGTH BEG  END                          CONTENTS
     -------------------------- ----   ------ ---------  -----------------------------------------------------------

                                                         COMMON ALIAS: BIC
                                                         DA3 ALIAS: BENE_IDENT_CODE
                                                         DB2 ALIAS: BENE_IDENT_CD
                                                         SAS ALIAS: BIC
                                                         STANDARD ALIAS: BENE_IDENT_CD
                                                         TITLE ALIAS: BIC

                                                         EDIT-RULES:
                                                         EDB REQUIRED FIELD

                                                         CODES:
                                                           REFER TO: BENE_IDENT_TB
                                                                     IN THE CODES APPENDIX

                                                         SOURCE:
                                                         SSA/RRB

     8. Beneficiary Race Code       CHAR    1   32  32  The race of a beneficiary.

                                                         DA3 ALIAS: RACE_CODE
                                                         DB2 ALIAS: BENE_RACE_CD
                                                         SAS ALIAS: RACE
                                                         STANDARD ALIAS: BENE_RACE_CD
                                                         SYSTEM ALIAS: LTRACE
                                                         TITLE ALIAS: RACE_CD

                                                         CODES:
                                                         0 = Unknown
                                                         1 = White
                                                         2 = Black
                                                         3 = Other
                                                         4 = Asian
                                                         5 = Hispanic
                                                         6 = North American Native

                                                         SOURCE:
                                                         SSA

     9. Beneficiary Residence SSA   CHAR    3   33  35  The SSA standard county code of a beneficiary's residence.
        Standard County Code

                                                         DA3 ALIAS: SSA_STANDARD_COUNTY_CODE
                                                         DB2 ALIAS: BENE_SSA_CNTY_CD
                                                         SAS ALIAS: CNTY_CD
                                                         STANDARD ALIAS: BENE_RSDNC_SSA_STD_CNTY_CD
                                                         TITLE ALIAS: BENE_COUNTY_CD
```

```
                                      EDIT-RULES:
                                      OPTIONAL: MAY BE BLANK

                                      SOURCE:
                                      SSA/EDB


1        FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

                                  POSITIONS
            NAME           TYPE  LENGTH BEG  END                        CONTENTS
   -------------------------  ----  ------ ---------  -------------------------------------------------------------


   10. Beneficiary Residence SSA   CHAR     2     36   37  The SSA standard state code of a beneficiary's residence.
       Standard State Code
                                                          DA3 ALIAS: SSA_STANDARD_STATE_CODE
                                                          DB2 ALIAS: BENE_SSA_STATE_CD
                                                          SAS ALIAS: STATE_CD
                                                          STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD
                                                          TITLE ALIAS: BENE_STATE_CD


                                                          EDIT-RULES:
                                                          OPTIONAL: MAY BE BLANK

                                                          CODES:
                                                            REFER TO: GEO_SSA_STATE_TB
                                                                      IN THE CODES APPENDIX

                                                          COMMENT:
                                                          1. Used in conjunction with a county code, as
                                                             selection criteria for the determination of
                                                             payment rates for HMO reimbursement.
                                                          2. Concerning individuals directly billable for
                                                             Part B and/or Part A premiums, this element
                                                             is used to determine if the beneficiary
                                                             will receive a bill in English or Spanish.
                                                          3. Also used for special studies.

                                                          SOURCE:
                                                          SSA/EDB

   11. Beneficiary Sex            CHAR     1     38   38  The sex of a beneficiary.
       Identification Code
                                                          COMMON ALIAS: SEX_CD
                                                          DA3 ALIAS: SEX_CODE
                                                          DB2 ALIAS: BENE_SEX_IDENT_CD
                                                          SAS ALIAS: SEX
                                                          STANDARD ALIAS: BENE_SEX_IDENT_CD
                                                          SYSTEM ALIAS: LTSEX
                                                          TITLE ALIAS: SEX_CD

                                                          EDIT-RULES:
                                                          REQUIRED FIELD

                                                          CODES:
                                                          1 = Male
                                                          2 = Female
                                                          0 = Unknown
```

12. Claim Attending Physician   CHAR   6   39   44   On an institutional claim, the unique
    UPIN Number   physician identification number (UPIN) of the
                                                       physician who would normally be expected to
                                                       certify and recertify the medical necessity of

```
                                    POSITIONS
               NAME              TYPE  LENGTH BEG  END                      CONTENTS
    -------------------------    ----  ------ ---------  -------------------------------------------------------------
```

                                                       the services rendered and/or who has primary
                                                       responsibility for the beneficiary's medical
                                                       care and treatment (attending physician).

                                                       This field is ENCRYPTED for the ENCRYPTED
                                                       Standard View of the Outpatient files.

                                                       COMMON ALIAS: ATTENDING_PHYSICIAN_UPIN
                                                       DB2 ALIAS: ATNDG_UPIN
                                                       SAS ALIAS: AT_UPIN
                                                       STANDARD ALIAS: CLM_ATNDG_PHYSN_UPIN_NUM
                                                       TITLE ALIAS: ATTENDING_PHYSICIAN

                                                       COMMENT:
                                                       Prior to Version H this field was named:
                                                       CLM_PRMRY_CARE_PHYSN_IDENT_NUM and contained
                                                       10 positions (6-position UPIN and 4-position
                                                       physician surname).

                                                       SOURCE:
                                                       CWF

13. Claim Diagnosis E Code   CHAR   5   45   49   Effective with Version H, the ICD-9-CM code
                                                       used to identify the external cause of injury,
                                                       poisoning, or other adverse affect. Redundantly
                                                       this field is also stored as the last occurrence
                                                       of the diagnosis trailer.

                                                       NOTE: During the Version H conversion, the data
                                                       in the last occurrence of the diagnosis trailer
                                                       was used to populate history.

                                                       DB2 ALIAS: CLM_DGNS_E_CD
                                                       SAS ALIAS: DGNS_E
                                                       STANDARD ALIAS: CLM_DGNS_E_CD
                                                       TITLE ALIAS: DGNS_E_CD

                                                       SOURCE:
                                                       CWF

14. Claim Excepted/Nonexcepted CHAR   1   50   50   Effective with Version I, the code used to identify
    Medical Treatment Code   whether or not the medical care or treatment received
                                                       by a beneficiary, who has elected care from a

Religious Nonmedical Health Care Institution (RNHCI),
is excepted or nonexcepted. Excepted is medical care
or treatment that is received involuntarily or is re-
quired under Federal, State or local law. Nonexcepted is
defined as medical care or treatment other than excepted.

DB2 ALIAS: EXCPTD_NEXCPTD_CD
SAS ALIAS: TRTMT_CD
STANDARD ALIAS: CLM_EXCPTD_NEXCPTD_TRTMT_CD
TITLE ALIAS: EXCPTD_NEXCPTD_CD

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS
					CODES:
					0 = No Entry
					1 = Excepted
					2 = Nonexcepted
					SOURCE:
					CWF
15. Claim Facility Type Code	CHAR	1	51	51	The first digit of the type of bill (TOB1) submitted on an institutional claim used to identify the type of facility that provided care to the beneficiary.

COMMON ALIAS: TOB1
DB2 ALIAS: CLM_FAC_TYPE_CD
SAS ALIAS: FAC_TYPE
STANDARD ALIAS: CLM_FAC_TYPE_CD
TITLE ALIAS: TOB1

CODES:
  REFER TO: CLM_FAC_TYPE_TB
            IN THE CODES APPENDIX

SOURCE:
CWF

16. Claim Frequency Code   CHAR   1   52   52   The third digit of the type of bill (TOB3) submitted on an
institutional claim record to indicate the sequence of a
claim in the beneficiary's current episode of care.

COMMON ALIAS: TOB3
DB2 ALIAS: CLM_FREQ_CD
SAS ALIAS: FREQ_CD
STANDARD ALIAS: CLM_FREQ_CD
SYSTEM ALIAS: LTFREQ
TITLE ALIAS: FREQUENCY_CD

CODES:
  REFER TO: CLM_FREQ_TB
            IN THE CODES APPENDIX

SOURCE:

```
                                          CWF

   ***  Claim Locator Number Group  GROUP    11   53   63  This number uniquely identifies the beneficiary in the
                                                           NCH Nearline.

                                                           STANDARD ALIAS: CLM_LCTR_NUM_GRP

   17. Beneficiary Claim Account    CHAR     9    53   61  The first nine characters identify the primary
       Number                                              beneficiary under the SSA or RRB programs submitted.

                                                           This field is ENCRYPTED for the ENCRYPTED
                                                           Standard View of the Outpatient files.

1        FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

                                          POSITIONS
               NAME                TYPE  LENGTH BEG  END                        CONTENTS
   ------------------------------  ----  ------ ---------  ------------------------------------------------------------

                                                           STANDARD ALIAS: BENE_CLM_ACNT_NUM

                                                           LIMITATIONS:
                                                           RRB-issued numbers contain an overpunch in
                                                           the first position that may appear as a plus
                                                           zero or A-G.   RRB-formatted numbers may
                                                           cause matching problems on non-IBM machines.

   18. NCH Category Equatable       CHAR     2    62   63  These two characters are the code categorizing
       Beneficiary Identification                          groups of BICs representing similar relationships
       Code                                                between the beneficiary and the primary wage
                                                           earner. The equatable BIC module electronically
                                                           matches two records that contain different BICs
                                                           where it is apparent that both are records for
                                                           the same beneficiary. It validates the BIC and
                                                           returns a base BIC under which to house the
                                                           record in the National Claims History (NCH)
                                                           databases. (All records for a beneficiary are
                                                           stored under a single BIC.)

                                                           For the ENCRYPTED Standard View, this field
                                                           contains the Beneficiary Identification Code.
                                                           (See Field #7 of the FI Outpatient Claim Fixed
                                                           Group - Encrypted Standard View.)

   19. Claim MCO Paid Switch        CHAR     1    64   64  A switch indicating whether or not a Managed Care
                                                           Organization (MCO) has paid the provider for an
                                                           institutional claim.

                                                           COBOL ALIAS: MCO_PD_IND
                                                           DB2 ALIAS: CLM_MCO_PD_SW
                                                           SAS ALIAS: MCOPDSW
                                                           STANDARD ALIAS: CLM_MCO_PD_SW
                                                           TITLE ALIAS: MCO_PAID_SW

                                                           CODES:
                                                           1 = MCO has paid the provider for a claim
                                                           Blank or 0 = MCO has not paid the provider
                                                                       for a claim
```

```
                                           COMMENT:
                                           Prior to Version H this field was named:
                                           CLM_GHO_PD_SW.

                                           SOURCE:
                                           CWF

    20. Claim Medicare Non Payment    CHAR     1    65   65   The reason that no Medicare payment is made for
        Reason Code                                           services on an institutional claim.

                                           NOTE:  Effective with Version I, this field was
                                                  put on all institutional claim types.
                                                  Prior to Version I, this field was present
                                                  only on inpatient claims.
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                          POSITIONS
             NAME                 TYPE  LENGTH BEG  END                        CONTENTS
    --------------------------    ----  ------ ---------   ------------------------------------------------------

                                           DB2 ALIAS: MDCR_NPMT_RSN_CD
                                           SAS ALIAS: NOPAY_CD
                                           STANDARD ALIAS: CLM_MDCR_NPMT_RSN_CD
                                           SYSTEM ALIAS: LTNPMT
                                           TITLE ALIAS: NON_PAYMENT_REASON

                                           EDIT-RULES:
                                           OPTIONAL

                                           CODES:
                                             REFER TO: CLM_MDCR_NPMT_RSN_TB
                                                          IN THE CODES APPENDIX

                                           SOURCE:
                                           CWF

    21. Claim Operating Physician    CHAR     6    66   71   On an institutional claim, the unique physician
        UPIN Number                                          identification number (UPIN) of the physician
                                                             who performed the principal procedure.  This
                                                             element is used by the provider to identify the
                                                             operating physician who performed the
                                                             surgical procedure.

                                                             This field is ENCRYPTED for the ENCRYPTED
                                                             Standard View of the Outpatient files.

                                           DB2 ALIAS: OPRTG_UPIN
                                           SAS ALIAS: OP_UPIN
                                           STANDARD ALIAS: CLM_OPRTG_PHYSN_UPIN_NUM
                                           TITLE ALIAS: OPRTG_UPIN

                                           COMMENT:
                                           Prior to Version H this field was named:
                                           CLM_PRNCPAL_PRCDR_PHYSN_NUM and contained
                                           10 positions (6-position UPIN and 4-position
                                           physician surname.
```

```
                              NOTE:  For HHA and Hospice formats beginning
                              with NCH weekly process date 10/3/97 this field
                              was populated with data.  HHA and Hospice claims
                              processed prior to 10/3/97 will contain spaces.

                              SOURCE:
                              CWF

22. Claim Other Physician UPIN   CHAR    6    72   77   On an institutional claim, the unique physician
    Number                                              identification number (UPIN) of the other
                                                        physician associated with the institutional
                                                        claim.

                              This field is ENCRYPTED for the ENCRYPTED
                              Standard View of the Outpatient files.
```

```
                                     POSITIONS
          NAME               TYPE  LENGTH BEG  END                        CONTENTS
--------------------------   ----  ------ ---------   -----------------------------------------------------------

                              DB2 ALIAS: OTHR_UPIN
                              SAS ALIAS: OT_UPIN
                              STANDARD ALIAS: CLM_OTHR_PHYSN_UPIN_NUM
                              TITLE ALIAS: OTH_PHYSN_UPIN

                              COMMENT:
                              Prior to Version H this field was named:
                              CLM_OTHR_PHYSN_IDENT_NUM and contained
                              10 positions (6-position UPIN and 4-position
                              other physician surname).

                              NOTE:  For HHA and Hospice formats beginning
                              with NCH weekly process date 10/3/97 this field
                              was populated with data.  HHA and Hospice claims
                              processed prior to 10/3/97 will contain spaces.

                              SOURCE:
                              CWF

23. Claim Outpatient             CHAR    13   78   90   Effective with version H, the amount paid by the
    Beneficiary Interim                                 beneficiary  that is being applied to the
    Deductible Amount                                   deductible, as reported on the outpatient claim.

                              NOTE: Beginning with NCH weekly process date
                              10/3/97 this field was populated with data.
                              Claims processed prior to 10/3/97 will contain
                              zeroes in this field.

                              9.2 DIGITS SIGNED

                              DB2 ALIAS: INTRM_DDCTBL_AMT
                              SAS ALIAS: INTRMDED
                              STANDARD ALIAS: CLM_OP_BENE_INTRM_DDCTBL_AMT
                              TITLE ALIAS: INTRM_DDCTBL
```

```
                                              EDIT-RULES:
                                              +9(9).99

                                              SOURCE:
                                              CWF

 24. Claim Outpatient          CHAR    13   91  103  Effective with Version H, the amount paid to the
     Beneficiary Payment                           beneficiary for the services reported on the
     Amount                                        outpatient claim.

                                              NOTE: Beginning with NCH weekly process date
                                              10/3/97 this field was populated with data.
                                              Claims processed prior to 10/3/97 will contain
                                              zeroes in this field.

                                              9.2 DIGITS SIGNED

 1        FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

                                     POSITIONS
                 NAME            TYPE  LENGTH BEG  END                     CONTENTS
     -------------------------- ---- ------ --------- ------------------------------------------------------------

                                              DB2 ALIAS: OP_BENE_PMT_AMT
                                              SAS ALIAS: BENEPMT
                                              STANDARD ALIAS: CLM_OP_BENE_PMT_AMT
                                              TITLE ALIAS: OP_BENE_PMT

                                              EDIT-RULES:
                                              +9(9).99

                                              SOURCE:
                                              CWF

 25. Claim Outpatient ESRD      CHAR     1  104  104  Effective with Version H, the code denoting the
     Method of Reimbursement                       method of reimbursement selected by the ESRD bene
     Code                                          for home dialysis (i.e. whether home supplies
                                              are purchased through a facility or from a supplier.)

                                              NOTE: Beginning with NCH weekly process date
                                              10/3/97 this field was populated with data.
                                              Claims processed prior to 10/3/97 will contain
                                              spaces in this field.

                                              DB2 ALIAS: ESRD_REIMBRSMT_CD
                                              SAS ALIAS: ESRDMTHD
                                              STANDARD ALIAS: CLM_OP_ESRD_MTHD_REIMBRSMT_CD
                                              TITLE ALIAS: ESRD_REIMBRSMT_MTHD

                                              CODES:
                                              0 = Not ESRD
                                              1 = Method 1 - Home supplies purchased
                                                  through a facility
                                              2 = Method 2 - Home supplies purchased
                                                  from a supplier.

                                              SOURCE:
```

CWF

26. Claim Outpatient Provider   CHAR   13   105 117   Effective with Version H, the amount paid to the
    Payment Amount   provider for the services reported on the
                                                          outpatient claim.

                                                          NOTE: Beginning with NCH weekly process date 10/3/97
                                                          this field was populated with data. Claims processed
                                                          prior to 10/3/97 will contain zeros in this field.

                                                          9.2 DIGITS SIGNED

                                                          DB2 ALIAS: OP_PRVDR_PMT_AMT
                                                          SAS ALIAS: PRVDRPMT
                                                          STANDARD ALIAS: CLM_OP_PRVDR_PMT_AMT
                                                          TITLE ALIAS: OP_PRVDR_PMT

                                      POSITIONS
                NAME   TYPE LENGTH BEG END   CONTENTS
         ------------------------- ---- ------ ---------   --

                                                          EDIT-RULES:
                                                          +9(9).99

                                                          SOURCE:
                                                          NCH

27. Claim Outpatient Referral   CHAR   1   118 118   The code indicating the means by which the
    Code   beneficiary was referred for outpatient services.

                                                          DB2 ALIAS: CLM_OP_RFRL_CD
                                                          SAS ALIAS: OP_RFRL
                                                          STANDARD ALIAS: CLM_OP_RFRL_CD
                                                          SYSTEM ALIAS: LTORFRL
                                                          TITLE ALIAS: OP_REFERRAL_CODE

                                                          CODES:
                                                            REFER TO: CLM_OP_RFRL_TB
                                                                      IN THE CODES APPENDIX

                                                          SOURCE:
                                                          CWF

28. Claim Outpatient Service   CHAR   1   119 119   Code indicating type and priority of outpatient
    Type Code   services.

                                                          DB2 ALIAS: OP_SRVC_TYPE_CD
                                                          SAS ALIAS: OPSRVTYP
                                                          STANDARD ALIAS: CLM_OP_SRVC_TYPE_CD
                                                          TITLE ALIAS: OP_SERVICE_TYPE_CODE

                                                          CODES:
                                                            REFER TO: CLM_OP_SRVC_TYPE_TB
                                                                      IN THE CODES APPENDIX

29. Claim Outpatient   CHAR   1   120 120   Effective with Version H, the code derived

Transaction Type Code

at CWF based on type of bill and provider number
to identify the outpatient transaction type.

NOTE: Beginning with NCH weekly process date
10/3/97 this field was populated with data.
Claims processed prior to 10/3/97 will contain
spaces in this field.

DB2 ALIAS: OP_TRANS_TYPE_CD
SAS ALIAS: TRANTYPE
STANDARD ALIAS: CLM_OP_TRANS_TYPE_CD
TITLE ALIAS: OP_TRANS_TYPE

CODES:
  REFER TO: CLM_OP_TRANS_TYPE_TB
            IN THE CODES APPENDIX

SOURCE:
CWF

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS
30. Claim Payment Amount	CHAR	13	121	133	Amount of payment made from the Medicare trust fund for the

Amount of payment made from the Medicare trust fund for the
services covered by the claim record. Generally, the amount
is calculated by the FI or carrier; and represents what was
paid to the institutional provider, physician, or supplier,
with the exceptions noted below. **NOTE: In some
situations, a negative claim payment amount may be pre-
sent; e.g., (1) when a beneficiary is charged the full
deductible during a short stay and the deductible exceeded
the amount Medicare pays; or (2) when a beneficiary is
charged a coinsurance amount during a long stay and the
coinsurance amount exceeds the amount Medicare pays (most
prevalent situation involves psych hospitals who are paid a
daily per diem rate no matter what the charges are.)

Under IP PPS, inpatient hospital services are paid based on
a predetermined rate per discharge, using the DRG patient
classification system and the PRICER program.   On the IP
PPS claim, the payment amount includes the DRG outlier
approved payment amount, disproportionate share (since
5/1/86), indirect medical education (since 10/1/88), total
PPS capital (since 10/1/91).   It does NOT include the pass
thru amounts (i.e., capital-related costs, direct medical
education costs, kidney acquisition costs, bad debts); or
any beneficiary-paid amounts (i.e., deductibles and
coinsurance); or any other payer reimbursement.

Under SNF PPS, SNFs will classify beneficiaries using the
patient classification system known as RUGS III. For the
SNF PPS claim, the SNF PRICER will calculate/return the rate
for each revenue center line item with revenue center code =
'0022'; multiply the rate times the units count; and then
sum the amount payable for all lines with revenue center

code '0022' to determine the total claim payment amount.

Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total payment. The Medicare payment amount takes into account the wage index adjustment and the beneficiary deductible and coinsurance amounts. NOTE: There is no CWF edit check to validate that the revenue center Medicare payment amount equals the claim level Medicare payment amount.

Under Home Health PPS, beneficiaries will be classified into an appropriate case mix category known as the Home Health Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG).

For the RAP, the PRICER will determine the payment amount appropriate to the HIPPS code by computing 60% (for first episode) or 50% (for subsequent episodes) of the case mix episode payment. The payment is then wage index adjusted.

| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS

For the final claim, PRICER calculates 100% of the amount due, because the final claim is processed as an adjustment to the RAP, reversing the RAP payment in full. Although final claim will show 100% payment amount, the provider will actually receive the 40% or 50% payment.

Exceptions: For claims involving demos and BBA encounter data, the amount reported in this field may not just represent the actual provider payment.

For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.

For demo Ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services. To identify what the conventional provider Part A payment would have been, check value code = 'Y4'.   The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

For BBA encounter data (non-demo) -- 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the BBA plan.

```
                                  9.2 DIGITS SIGNED

                                  COMMON ALIAS: REIMBURSEMENT
                                  DB2 ALIAS: CLM_PMT_AMT
                                  SAS ALIAS: PMT_AMT
                                  STANDARD ALIAS: CLM_PMT_AMT
                                  TITLE ALIAS: REIMBURSEMENT

                                  EDIT-RULES:
                                  +9(9).99

                                  COMMENT:
                                  Prior to Version H the size of this field was S9(7)V99.
                                  Also the noninstitutional claim records carried this field
                                  as a line item.  Effective with Version H, this element is a
                                  claim level field across all claim types (and the line item
                                  has been renamed.)

                                  SOURCE:
                                  CWF
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                POSITIONS
              NAME          TYPE LENGTH BEG  END                       CONTENTS
   -------------------------- ---- ------ ---------  -----------------------------------------------------------
                                                  LIMITATIONS:
                                                  Prior to 4/6/93, on inpatient, outpatient, and
                                                  physician/supplier claims containing a
                                                  CLM_DISP_CD of '02', the amount shown as the Medicare
                                                  reimbursement does not take into consideration
                                                  any CWF automatic adjustments (involving erroneous
                                                  deductibles in most cases).  In as many as 30% of
                                                  the claims (30% IP, 15% OP, 5% PART B), the
                                                  reimbursement reported on the claims may be over
                                                  or under the actual Medicare payment amount.

   31. Claim PPS Indicator Code   CHAR    1   134  134  Effective with Version H, the code indicating
                                                  whether or not the (1) claim is PPS and/or (2)
                                                  the beneficiary is a deemed insured Medicare
                                                  Qualified Government Employee (MQGE).

                                                  NOTE:  Beginning with NCH weekly process date
                                                  10/3/97 through 5/29/98, this field was pop-
                                                  ulated with only the PPS indicator.  Beginning with
                                                  NCH weekly process date 6/5/98, this field was
                                                  additionally populated with the deemed MQGE
                                                  indicator. Claims processed prior to 10/3/97
                                                  will contain spaces.

                                                  COBOL ALIAS: PPS_IND
                                                  DB2 ALIAS: CLM_PPS_IND_CD
                                                  SAS ALIAS: PPS_IND
                                                  STANDARD ALIAS: CLM_PPS_IND_CD
                                                  TITLE ALIAS: PPS_IND
```

```
                                    CODES:
                                      REFER TO: CLM_PPS_IND_TB
                                                IN THE CODES APPENDIX

                                    SOURCE:
                                    CWF

    32. Claim Principal Diagnosis   CHAR    5   135  139   The ICD-9-CM diagnosis code identifying the diagnosis,
        Code                                                condition, problem or other reason for the
                                                            admission/encounter/visit shown in the medical record to be
                                                            chiefly responsible for the services provided.

                                    NOTE:  Effective with Version H, this data is also
                                    redundantly stored as the first occurrence of the diagnosis
                                    trailer.

                                    DB2 ALIAS: PRNCPAL_DGNS_CD
                                    SAS ALIAS: PDGNS_CD
                                    STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD
                                    TITLE ALIAS: PRINCIPAL_DIAGNOSIS

                                    EDIT-RULES:
                                    ICD-9-CM
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                              POSITIONS
                  NAME              TYPE  LENGTH BEG  END                          CONTENTS
        --------------------------  ----  ------ ---------  ------------------------------------------------------------

                                    SOURCE:
                                    CWF


    33. Claim Query Code            CHAR    1   140  140   Code indicating the type of claim record being processed
                                                            with respect to payment (debit/credit indicator;
                                                            interim/final indicator).

                                    DB2 ALIAS: CLM_QUERY_CD
                                    SAS ALIAS: QUERY_CD
                                    STANDARD ALIAS: CLM_QUERY_CD
                                    TITLE ALIAS: QUERY_CD

                                    CODES:
                                    0 = Credit adjustment
                                    1 = Interim bill
                                    2 = Home Health Agency (HHA) benefits
                                        exhausted (obsolete 7/98)
                                    3 = Final bill
                                    4 = Discharge notice (obsolete 7/98)
                                    5 = Debit adjustment

                                    SOURCE:
                                    CWF

    34. Claim Service               CHAR    1   141  141   The second digit of the type of bill (TOB2) submitted on an
        Classification Type Code                            institutional claim record to indicate the classification of
```

the type of service provided to the beneficiary.

                                    COMMON ALIAS: TOB2
                                    DB2 ALIAS: SRVC_CLSFCTN_CD
                                    SAS ALIAS: TYPESRVC
                                    STANDARD ALIAS: CLM_SRVC_CLSFCTN_TYPE_CD
                                    TITLE ALIAS: TOB2

                                    CODES:
                                      REFER TO: CLM_SRVC_CLSFCTN_TYPE_TB
                                                IN THE CODES APPENDIX

                                    SOURCE:
                                    CWF

    35. Claim Through Date   NUM   8   142 149   The last day on the billing statement covering
                                                           services rendered to the beneficiary (a.k.a
                                                           'Statement Covers Thru Date').

                                                           For the ENCRYPTED Standard View of the
                                                           Outpatient files, the claim through
                                                           date is coded as the quarter of the
                                                           calendar year when the claim through
                                                           date occurred.

                                              POSITIONS
                NAME   TYPE LENGTH BEG END   CONTENTS
    --------------------------   ---- ------ ---------   --

                                                           NOTE: For Home Health PPS claims, the 'from'
                                                           date and the 'thru' date on the RAP (initial
                                                           claim) must always match.

                                                           8 DIGITS UNSIGNED

                                                           DB2 ALIAS: CLM_THRU_DT
                                                           SAS ALIAS: THRU_DT
                                                           STANDARD ALIAS: CLM_THRU_DT
                                                           TITLE ALIAS: THRU_DATE

                                                           EDIT-RULES FOR ENCRYPTED DATA:
                                                           YYYYQ000 WHERE Q IS ONE OF THE
                                                           FOLLOWING VALUES.
                                                           1 = FIRST QUARTER OF THE CALENDAR YEAR
                                                           2 = SECOND QUARTER OF THE CALENDAR YEAR
                                                           3 = THIRD QUARTER OF THE CALENDAR YEAR
                                                           4 = FOURTH QUARTER OF THE CALENDAR YEAR

                                                           SOURCE:
                                                           CWF

    36. Claim Total Charge Amount   CHAR   13   150 162   Effective with Version G, the total charges for
                                                           all services included on the institutional claim.
                                                           This field is redundant with revenue center
                                                           code 0001/total charges.

```
                                9.2 DIGITS SIGNED

                                DB2 ALIAS: CLM_TOT_CHRG_AMT
                                SAS ALIAS: TOT_CHRG
                                STANDARD ALIAS: CLM_TOT_CHRG_AMT
                                TITLE ALIAS: CLAIM_TOTAL_CHARGES

                                EDIT-RULES:
                                +9(9).99

                                COMMENT:
                                Prior to Version H the size of this field was
                                S9(7)V99.

                                SOURCE:
                                CWF

    37. Claim Transaction Code      CHAR    1   163  163   The code derived by CWF to indicate the type of claim
                                                           submitted by an institutional provider.

                                DB2 ALIAS: CLM_TRANS_CD
                                SAS ALIAS: TRANS_CD
                                STANDARD ALIAS: CLM_TRANS_CD
                                SYSTEM ALIAS: LTCLTRAN
                                TITLE ALIAS: TRANSACTION_CODE
```

```
                                                POSITIONS
                   NAME           TYPE  LENGTH BEG  END                        CONTENTS
         --------------------------  ----  ------ ---------  --------------------------------------------------------

                                CODES:
                                  REFER TO: CLM_TRANS_TB
                                            IN THE CODES APPENDIX

                                SOURCE:
                                CWF

    38. CWF Beneficiary Medicare    CHAR    2   164  165   The CWF-derived reason for a beneficiary's
        Status Code                                        entitlement to Medicare benefits, as of the
                                                           reference date (CLM_THRU_DT).

                                COBOL ALIAS: MSC
                                COMMON ALIAS: MSC
                                DB2 ALIAS: BENE_MDCR_STUS_CD
                                SAS ALIAS: MS_CD
                                STANDARD ALIAS: CWF_BENE_MDCR_STUS_CD
                                SYSTEM ALIAS: LTMSC
                                TITLE ALIAS: MSC

                                DERIVATION:
                                CWF derives MSC from the following:
                                  1.  Date of Birth
                                  2.  Claim Through Date
                                  3.  Original/Current Reasons for entitlement
                                  4.  ESRD Indicator
                                  5.  Beneficiary Claim Number
```

Items 1,3,4,5 come from the CWF Beneficiary
Master Record; item 2 comes from the FI/Carrier
claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

CODES:
10 = Aged without ESRD
11 = Aged with ESRD
20 = Disabled without ESRD
21 = Disabled with ESRD
31 = ESRD only

COMMENT:
Prior to Version H this field was named:
BENE_MDCR_STUS_CD. The name has been changed
to distinguish this CWF-derived field from the
EDB-derived MSC (BENE_MDCR_STUS_CD).

SOURCE:
CWF

```
                                    POSITIONS
                NAME          TYPE  LENGTH BEG  END                              CONTENTS
      --------------------------    ----  ------ ---------  ------------------------------------------------------------

      39. FI Claim Action Code      CHAR     1   166  166   The type of action requested by the intermediary
                                                            to be taken on an institutional claim.

                                                            DB2 ALIAS: FI_CLM_ACTN_CD
                                                            SAS ALIAS: ACTIONCD
                                                            STANDARD ALIAS: FI_CLM_ACTN_CD
                                                            TITLE ALIAS: ACTION_CD

                                                            CODES:
                                                              REFER TO: FI_CLM_ACTN_TB
                                                                        IN THE CODES APPENDIX

                                                            COMMENT:
                                                            Prior to Version H this field was named:
                                                            INTRMDRY_CLM_ACTN_CD.

                                                            SOURCE:
                                                            CWF

      40. FI Number                 CHAR     5   167  171   The identification number assigned by HCFA to a fiscal
                                                            intermediary authorized to process institutional claim
                                                            records.

                                                            DB2 ALIAS: FI_NUM
```

```
                                        SAS ALIAS: FI_NUM
                                        STANDARD ALIAS: FI_NUM
                                        SYSTEM ALIAS: LTFI
                                        TITLE ALIAS: INTERMEDIARY


                                        CODES:
                                          REFER TO: FI_NUM_TB
                                                    IN THE CODES APPENDIX


                                        COMMENT:
                                        Prior to Version H this field was named:
                                        FICARR_IDENT_NUM.


                                        SOURCE:
                                        CWF

     41. FI Requested Claim Cancel      CHAR     1  172  172   The reason that an intermediary requested cancelling
         Reason Code                                           a previously submitted institutional claim.


                                        DB2 ALIAS: RQST_CNCL_RSN_CD
                                        SAS ALIAS: CANCELCD
                                        STANDARD ALIAS: FI_RQST_CLM_CNCL_RSN_CD
                                        TITLE ALIAS: CANCEL_CD


                                        CODES:
                                          REFER TO: FI_RQST_CLM_CNCL_RSN_TB
                                                    IN THE CODES APPENDIX

1        FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002


                                        POSITIONS
               NAME                 TYPE  LENGTH BEG  END               CONTENTS
     -------------------------      ----  ------ ---------  ------------------------------------------------------------


                                        COMMENT:
                                        Prior to Version H this field was named:
                                        INTRMDRY_RQST_CLM_CNCL_RSN_CD.


                                        SOURCE:
                                        CWF

     42. NCH Beneficiary Blood         CHAR    13  173  185   The amount of money for which the intermediary
         Deductible Liability Amount                          determined the beneficiary is liable for the blood
                                                              deductible.


                                        9.2 DIGITS SIGNED


                                        DB2 ALIAS: BLOOD_DDCTBL_AMT
                                        SAS ALIAS: BLDDEDAM
                                        STANDARD ALIAS: NCH_BENE_BLOOD_DDCTBL_AMT
                                        TITLE ALIAS: BLOOD_DEDUCTIBLE


                                        EDIT-RULES:
                                        +9(9).99


                                        DERIVATION:
                                        DERIVED FROM:
                                          CLM_VAL_CD
```

```
                    CLM_VAL_AMT

                    DERIVATION RULES:
                    Based on the presence of value code equal to
                    '06' move the corresponding value amount to
                    NCH_BENE_BLOOD_DDCTBL_AMT.

                    COMMENT:
                    Prior to Version H, this field was named:
                    BENE_BLOOD_DDCTBL_LBLTY_AMT and the field
                    size was S9(5)V99.  Also, for OP claims, this
                    field was stored in a blood trailer.  Version
                    H eliminated the OP blood trailer.

                    SOURCE:
                    NCH QA PROCESS

    43. NCH Beneficiary Part B      CHAR    13   186  198   The amount of money for which the
        Coinsurance Amount                                  intermediary has determined that the
                                                            beneficiary is liable for Part B
                                                            coinsurance on the institutional
                                                            claim.

                                                            9.2 DIGITS SIGNED

                                                            DB2 ALIAS: PTB_COINSRNC_AMT
                                                            SAS ALIAS: PTB_COIN
                                                            STANDARD ALIAS: NCH_BENE_PTB_COINSRNC_AMT
                                                            TITLE ALIAS: BENE_PTB_COINSURANCE_AMT
```
```
                                      POSITIONS
                  NAME           TYPE  LENGTH BEG  END                          CONTENTS
        -------------------------- ---- ------ ---------  ----------------------------------------------------------

                                                            EDIT-RULES:
                                                            +9(9).99

                                                            DERIVATION:
                                                            DERIVED FROM:
                                                              CLM_VAL_CD
                                                              CLM_VAL_AMT

                                                            DERIVATION RULES (Effective 10/93):
                                                            Based on the presence of value codes A2, B2
                                                            or C2 move the related value amount to the
                                                            NCH_BENE_PTB_COINSRNC_AMT.  *NOTE: Prior to
                                                            10/93, this field was present on the claim
                                                            transmitted by CWF.

                                                            COMMENT:
                                                            Prior to Version H this field was named:
                                                            BENE_PTB_COINSRNC_LBLTY_AMT and the field
                                                            size was s9(5)V99.

                                                            SOURCE:
                                                            NCH QA PROCESS
```

```
44. NCH Beneficiary Part B       CHAR   13  199 211   The amount of money for which the
    Deductible Amount                                 intermediary or carrier has determined
                                                      that the beneficiary is liable for the
                                                      Part B cash deductible on the claim.

                                                      9.2 DIGITS SIGNED

                                                      DB2 ALIAS: NCH_PTB_DDCTBL_AMT
                                                      SAS ALIAS: PTB_DED
                                                      STANDARD ALIAS: NCH_BENE_PTB_DDCTBL_AMT
                                                      TITLE ALIAS: PTB_DDCTBL

                                                      EDIT RULES:
                                                      +9(9).99

                                                      DERIVATION:
                                                      DERIVED FROM:
                                                        CLM_VAL_CD
                                                        CLM_VAL_AMT

                                                      DERIVATION RULES (Effective 10/93):
                                                      Based on the presence of value codes A1, B1,
                                                      or C1 move the related value amount to the
                                                      NCH_BENE_PTB_DDCTBL_LBLTY_AMT and field
                                                      size was s9(5)V99.

                                                      SOURCE:
                                                      NCH QA PROCESS
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                           POSITIONS
                    NAME            TYPE  LENGTH BEG  END                           CONTENTS
          -------------------------  ----  ------ ---------  ------------------------------------------------------------

45. NCH Blood Deductible Pints   CHAR    4   212 215   The quantity of blood pints applied (blood
    Quantity                                          deductible).

                                                      3 DIGITS SIGNED

                                                      DB2 ALIAS: BLOOD_DDCTBL_QTY
                                                      SAS ALIAS: BLDDEDPT
                                                      STANDARD ALIAS: NCH_BLOOD_DDCTBL_PT_QTY
                                                      TITLE ALIAS: BLOOD_PINTS_DEDUCTIBLE

                                                      EDIT-RULES:
                                                      +999

                                                      DERIVATION:
                                                      DERIVED FROM:
                                                        CLM_VAL_CD
                                                        CLM_VAL_AMT

                                                      DERIVATION RULES:
                                                      Based on the presence of value code equal to
                                                      38 move the related value amount to the
                                                      NCH_BLOOD_DDCTBL_PT_QTY.
```

```
                                   COMMENT:
                                   Prior to Version H this field was named:
                                   CLM_BLOOD_DDCTBL_PT_QTY.  Also for outpatient
                                   claims this field was stored in a blood
                                   trailer.  Version H eliminated the outpatient
                                   blood trailer.

                                   SOURCE:
                                   NCH QA Process

    46. NCH Blood Pints Furnished    CHAR    4   216  219   Number of whole pints of blood furnished to the
        Quantity                                            beneficiary.

                                   3 DIGITS SIGNED

                                   DB2 ALIAS: NCH_BLOOD_PT_FRNSH
                                   SAS ALIAS: BLDFRNSH
                                   STANDARD ALIAS: NCH_BLOOD_PT_FRNSH_QTY
                                   TITLE ALIAS: BLOOD_PINTS_FURNISHED

                                   EDIT-RULES:
                                   +999

                                   DERIVATION:
                                   DERIVED FROM:
                                     CLM_VAL_CD
                                     CLM_VAL_AMT
```

```
                                         POSITIONS
                NAME             TYPE  LENGTH BEG  END                      CONTENTS
    -------------------------   ----   ------ ---------   -----------------------------------------------------------

                                   DERIVATION RULES:
                                   Based on the presence of value code equal to
                                   37 move the related value amount to the
                                   NCH_BLOOD_PT_FRNSH_QTY.

                                   COMMENT:
                                   Prior to Version H this field was named:
                                   CLM_BLOOD_PT_FRNSH_QTY.  Also for outpatient
                                   claims this field was stored in a blood
                                   trailer.  Version H eliminated the outpatient
                                   blood trailer.

                                   SOURCE:
                                   NCH QA Process

    47. NCH Blood Pints Not       CHAR    4   220  223   Number of whole pints of blood not replaced.
        Replaced Quantity

                                   3 DIGITS SIGNED

                                   DB2 ALIAS: BLOOD_PT_NRPLC_QTY
                                   SAS ALIAS: BLDNRPLC
                                   STANDARD ALIAS: NCH_BLOOD_PT_NRPLC_QTY
                                   TITLE ALIAS: BLOOD_PINTS_NOT_REPLACED
```

```
                              EDIT-RULES:
                              +999

                              DERIVATION:
                              DERIVED FROM:
                                CLM_VAL_CD
                                CLM_VAL_AMT

                              DERIVATION RULES:
                              Subtract value code 39 amount from value code
                              37 amount and move the result to
                              NCH_BLOOD_PT_NRPLC_QTY.

                              COMMENT:
                              Prior to Version H this field was named:
                              CLM_BLOOD_PT_NRPLC_QTY.  Also for outpatient
                              claims this field was stored in a blood
                              trailer.  Version H eliminated the outpatient
                              blood trailer.

                              SOURCE:
                              NCH QA Process

    48. NCH Blood Pints Replaced      CHAR    4   224  227  Number of whole pints of blood replaced.
        Quantity

                              3 DIGITS SIGNED
```

```
                                    POSITIONS
                NAME              TYPE  LENGTH BEG  END                        CONTENTS
      -------------------------  ----  ------ ---------  ------------------------------------------------------

                              DB2 ALIAS: BLOOD_PT_RPLC_QTY
                              SAS ALIAS: BLD_RPLC
                              STANDARD ALIAS: NCH_BLOOD_PT_RPLC_QTY
                              TITLE ALIAS: BLOOD_PINTS_REPLACED

                              EDIT-RULES:
                              +999

                              DERIVATION:
                              DERIVED FROM:
                                CLM_VAL_CD
                                CLM_VAL_AMT

                              DERIVATION RULES:
                              Based on the presence of value code equal to
                              39 move the related value amount to the
                              NCH_BLOOD_PT_RPLC_QTY.

                              COMMENT:
                              Prior to Version H this field was named:
                              CLM_BLOOD_PT_RPLC_QTY.  Also for outpatient
                              claims this field was stored in a blood
                              trailer.  Version H eliminated the outpatient
                              blood trailer.
```

```
                                          SOURCE:
                                          NCH QA Process

    49. NCH Near Line Record       CHAR    1   228  228  A code defining the type of claim record being processed.
        Identification Code

                                          COMMON ALIAS:  RIC
                                          DB2 ALIAS:  NEAR_LINE_RIC_CD
                                          SAS ALIAS:  RIC_CD
                                          STANDARD ALIAS:  NCH_NEAR_LINE_RIC_CD
                                          TITLE ALIAS:  RIC

                                          CODES:
                                            REFER TO: NCH_NEAR_LINE_RIC_TB
                                                      IN THE CODES APPENDIX

                                          COMMENT:
                                          Prior to Version H this field was named:
                                          RIC_CD.

                                          SOURCE:
                                          NCH

    50. NCH Near-Line Record       CHAR    1   229  229  The code indicating the record version of the Nearline file
        Version Code                                     where the institutional, carrier or DMERC claims data are
                                                         stored:

1       FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

                                      POSITIONS
                 NAME              TYPE  LENGTH BEG  END                           CONTENTS
    -------------------------      ----  ------ ---------  ------------------------------------------------------------

                                          DB2 ALIAS:  NCH_REC_VRSN_CD
                                          SAS ALIAS:  REC_LVL
                                          STANDARD ALIAS:  NCH_NEAR_LINE_REC_VRSN_CD
                                          TITLE ALIAS:  NCH_VERSION

                                          CODES:
                                          A = Record format as of January 1991
                                          B = Record format as of April 1991
                                          C = Record format as of May 1991
                                          D = Record format as of January 1992
                                          E = Record format as of March 1992
                                          F = Record format as of May 1992
                                          G = Record format as of October 1993
                                          H = Record format as of September 1998
                                          I = Record format as of July 2000

                                          COMMENT:
                                          Prior to Version H this field was anmed:
                                          CLM_NEAR_LINE_REC_VRSN_CD.

                                          SOURCE:
                                          NCH

    51. NCH Payment and Edit Record  CHAR  1   230  230  The code used for payment and editing purposes that
        Identification Code                              indicates the type of institutional claim record.
```

```
                                    DB2 ALIAS: PMT_EDIT_RIC_CD
                                    SAS ALIAS: PE_RIC
                                    STANDARD ALIAS: NCH_PMT_EDIT_RIC_CD
                                    TITLE ALIAS: NCH_PAYMENT_EDIT_RIC

                                    CODES:
                                    C = Inpatient hospital, SNF
                                    D = Outpatient
                                    E = Religious Nonmedical Health Care Institutions (eff. 8/00
                                       Christian Science, prior to 7/00
                                    F = Home Health Agency (HHA)
                                    G = Discharge notice
                                       (obsoleted 7/98)
                                    I = Hospice

                                    COMMENT:
                                    Prior to Version H this field was named:
                                    PMT_EDIT_RIC_CD.

                                    SOURCE:
                                    NCH QA Process

    52. NCH Primary Payer Claim      CHAR   13   231  243   The amount of a payment made on behalf of a Medicare
        Paid Amount                                         beneficiary by a primary payer other than Medicare, that the
                                                            provider is applying to covered Medicare charges on an
                                                            institutional, carrier, or DMERC claim.
```

```
                                               POSITIONS
                   NAME               TYPE  LENGTH BEG  END                         CONTENTS
        -------------------------     ----  ------ ---------  --------------------------------------------------------

                                    9.2 DIGITS SIGNED

                                    DB2 ALIAS: PRMRY_PYR_PD_AMT
                                    SAS ALIAS: PRPAYAMT
                                    STANDARD ALIAS: NCH_PRMRY_PYR_CLM_PD_AMT
                                    TITLE ALIAS: PRIMARY_PAYER_AMOUNT

                                    EDIT-RULES:
                                    +9(9).99

                                    COMMENT:
                                    Prior to Version H this field was named:
                                    BENE_PRMRY_PYR_CLM_PMT_AMT and the field size
                                    was S9(7)V99.

                                    SOURCE:
                                    NCH

    53. NCH Primary Payer Code       CHAR    1   244  244   The code, on an institutional claim, specifying a federal
                                                            non-Medicare program or other source that has primary
                                                            responsibility for the payment of the Medicare beneficiary's
                                                            health insurance bills.

                                    DB2 ALIAS: NCH_PRMRY_PYR_CD
```

```
                         SAS ALIAS: PRPAY_CD
                         STANDARD ALIAS: NCH_PRMRY_PYR_CD
                         TITLE ALIAS: PRIMARY_PAYER_CD

                         DERIVATION:
                         DERIVED FROM:
                            CLM_VAL_CD
                            CLM_VAL_AMT

                         DERIVATION RULES

                           SET NCH_PRMRY_PYR_CD TO 'A' WHERE THE
                           CLM_VAL_CD = '12'

                           SET NCH_PRMRY_PYR_CD TO 'B' WHERE THE
                           CLM_VAL_CD = '13'

                           SET NCH_PRMRY_PYR_CD TO 'C' WHERE THE
                           CLM_VAL_CD = '16' and CLM_VAL_AMT is zeroes

                           SET NCH_PRMRY_PYR_CD TO 'D' WHERE THE
                           CLM_VAL_CD = '14'

                           SET NCH_PRMRY_PYR_CD TO 'E' WHERE THE
                           CLM_VAL_CD = '15'

                           SET NCH_PRMRY_PYR_CD TO 'F' WHERE THE
                           CLM_VAL_CD = '16' (CLM_VAL_AMT not
                           equal to zeroes)
```

```
                               POSITIONS
            NAME            TYPE  LENGTH BEG  END                          CONTENTS
---------------------------  ----  ------ ---------  ------------------------------------------------------------

                                                     SET NCH_PRMRY_PYR_CD TO 'G' WHERE THE
                                                     CLM_VAL_CD = '43'

                                                     SET NCH_PRMRY_PYR_CD TO 'H' WHERE THE
                                                     CLM_VAL_CD = '41'

                                                     SET NCH_PRMRY_PYR_CD TO 'I' WHERE THE
                                                     CLM_VAL_CD = '42'

                                                     SET NCH_PRMRY_PYR_CD TO 'L' (or prior to 4/97
                                                     set code to 'J') WHERE THE CLM_VAL_CD = '47'

                                                     CODES:
                                                       REFER TO: BENE_PRMRY_PYR_TB
                                                                 IN THE CODES APPENDIX

                                                     COMMENT:
                                                     Prior to Version H this field was named:
                                                     BENE_PRMRY_PYR_CD.

                                                     SOURCE:
                                                     NCH
```

```
54. NCH Professional Component    CHAR   13   245  257  Effective with Version H, for inpatient and out-
    Charge Amount                                        patient claims, the amount of physician and other
                                                         professional charges covered under Medicare Part B
                                                         (used for internal CWFMQA editing purposes and other
                                                         internal processes (e.g. if computing interim payment
                                                         these charges are deducted)).

                                                         NOTE:  During the Version H conversion this field
                                                         was populated with data throughout history (back to
                                                         service year 1991).

                                                         9.2 DIGITS SIGNED

                                                         DB2 ALIAS: PROFNL_CMPNT_AMT
                                                         SAS ALIAS: PCCHGAMT
                                                         STANDARD ALIAS: NCH_PROFNL_CMPNT_CHRG_AMT
                                                         TITLE ALIAS: PROFNL_CMPNT_CHARGES

                                                         EDIT-RULES:
                                                         +9(9).99

                                                         DERIVATION:

                                                         1. IF INPATIENT - DERIVED FROM:
                                                            CLM_VAL_CD
                                                            Clm_VAL_AMT

                                                         DERIVATION RULES:
                                                         Based on the presence of value code 04 or 05
                                                         move the related value amount to the
                                                         NCH_PROFNL_CMPNT_CHRG_AMT.
```

```
                                POSITIONS
            NAME            TYPE  LENGTH BEG  END                        CONTENTS
    -------------------------  ----  ------ ---------  -------------------------------------------------------

                                                         2. IF OUTPATIENT - DERIVED FROM:
                                                            REV_CNTR_CD
                                                            REV_CNTR_TOT_CHRG_AMT

                                                         DERIVATION RULES (Effective 10/98):
                                                         Based on the presence of revenue center codes
                                                         096X, 097X & 098X move the related total charge
                                                         amount to NCH_PROFNL_CMPNT_CHRG_AMT.

                                                         NOTE1:  During the Version H conversion, this
                                                         field was populated with data throughout history
                                                         BUT the derivation rule applied to the outpatient
                                                         claim was incomplete (i.e., revenue codes 0972,
                                                         0973, 0974 and 0979 were omitted from the calcu-
                                                         lation).

                                                         SOURCE:
                                                         NCH QA Process
```

```
   55. NCH Provider State Code    CHAR    2  258  259  Effective with Version H, the two position SSA state code
                                                       where provider facility is located.

                                                       NOTE:  During the Version H conversion this field was
                                                       populated with data throughout history (back to service year
                                                       1991).

                                                       DB2 ALIAS: NCH_PRVDR_STATE_CD
                                                       SAS ALIAS: PRSTATE
                                                       STANDARD ALIAS: NCH_PRVDR_STATE_CD
                                                       TITLE ALIAS: PROVIDER_STATE_CD

                                                       DERIVATION:
                                                       DERIVED FROM:
                                                          NCH PRVDR_NUM

                                                       DERIVATION RULES:

                                                         SET NCH_PRVDR_STATE_CD TO
                                                             PRVDR_NUM POS1-2.
                                                         FOR PRVDR_NUM POS1-2 EQUAL '55
                                                           SET NCH_PRVDR_STATE_CD TO '05'.
                                                         FOR PRVDR_NUM POS1-2 EQUAL '67
                                                           SET NCH_PRVDR_STATE_CD TO '45'.
                                                         FOR PRVDR_NUM POS1-2 EQUAL '68
                                                           SET NCH_PRVDR_STATE_CD TO '10'.

                                                       CODES:
                                                         REFER TO: GEO_SSA_STATE_TB
                                                                      IN THE CODES APPENDIX

                                                       SOURCE:
                                                       NCH
```

```
                                              POSITIONS
                NAME              TYPE  LENGTH BEG  END                         CONTENTS
     -------------------------    ----  ------ --------  -------------------------------------------------------------

   56. Outpatient Claim           NUM     2   260  261  The count of the number of diagnosis codes (both
       Diagnosis Code Count                             principal and other) reported on an outpatient
                                                        claim. The purpose of this count is to indicate
                                                        how many claim diagnosis trailers are present.

                                                        2 DIGITS UNSIGNED

                                                        DB2 ALIAS: OP_CLM_DGNS_CD_CNT
                                                        SAS ALIAS: OPDGNCNT
                                                        STANDARD ALIAS: OP_CLM_DGNS_CD_CNT

                                                        EDIT-RULES:
                                                        RANGE: 0 TO 10

                                                        COMMENT:
                                                        Prior to Version H this field was named:
                                                        CLM_OTHR_DGNS_CD_CNT and the principal was
                                                        not included in the count.
```

57. Outpatient Claim   NUM   2   262 263   The count of the number of procedure codes (both principal
    Procedure Code Count   and other) reported on an outpatient claim. The purpose
                                                        of this count is to indicate how many claim procedure
                                                        trailers are present.

                                              2 DIGITS UNSIGNED

                                              DB2 ALIAS: OP_PRCDR_CD_CNT
                                              SAS ALIAS: OPPRCNT
                                              STANDARD ALIAS: OP_CLM_PRCDR_CD_CNT

                                              EDIT-RULES:
                                              RANGE: 0 TO 6

                                              COMMENT:
                                              Prior to Version H this field was named:
                                              CLM_PRCDR_CD_CNT.

                                              SOURCE:
                                              CWF

58. Outpatient Claim Related NUM   2   264 265   The count of the number of condition codes reported
    Condition Code Count   on an outpatient claim. The purpose of this count
                                                        is to indicate how many condition code trailer are
                                                        present.

                                              2 DIGITS UNSIGNED

                                              DB2 ALIAS: OP_RLT_COND_CD_CNT
                                              SAS ALIAS: OPCONCNT
                                              STANDARD ALIAS: OP_CLM_RLT_COND_CD_CNT

                                          POSITIONS
               NAME   TYPE LENGTH BEG END   CONTENTS
      ------------------------- ---- ------ --------- ---

                                              EDIT-RULES:
                                              RANGE: 0 TO 30

                                              COMMENT:
                                              Prior to Version H this field was named:
                                              CLM_RLT_COND_CD_CNT.

                                              SOURCE:
                                              NCH

59. Outpatient Claim Related NUM   2   266 267   The count of the number of occurrence codes reported on
    Occurrence Code Count   reported on an outpatient claim. The purpose of this
                                                        count is to include how many occurrence code trailers
                                                        are present.

                                              2 DIGITS UNSIGNED

```
                                                DB2 ALIAS: OP_OCRNC_CD_CNT
                                                SAS ALIAS: OPOCRCNT
                                                STANDARD ALIAS: OP_CLM_RLT_OCRNC_CD_CNT

                                                EDIT-RULES:
                                                RANGE: 0 TO 30

                                                COMMENT:
                                                Prior to Version H this field was named:
                                                CLM_RLT_OCRNC_CD_CNT.

                                                SOURCE:
                                                NCH

     60. Outpatient Claim Value      NUM     2   268  269   The count of the number of value codes
         Code Count                                         reported on an outpatient claim. The
                                                            purpose of the count is to indicate how
                                                            many value code trailers are present.

                                                2 DIGITS UNSIGNED

                                                DB2 ALIAS: OP_CLM_VAL_CD_CNT
                                                SAS ALIAS: OPVALCNT
                                                STANDARD ALIAS: OP_CLM_VAL_CD_CNT

                                                EDIT-RULES:
                                                RANGE: 0 TO 36

                                                COMMENT:
                                                Prior to Version H this field was named:
                                                CLM_VAL_CD_CNT.

                                                SOURCE:
                                                NCH
```

```
                                      POSITIONS
             NAME              TYPE  LENGTH BEG  END                        CONTENTS
     -------------------------  ----  ------ --------   -----------------------------------------------------------

     61. Outpatient Revenue       NUM     2   270  271   The count of the number of revenue codes
         Center Code Count                               reported on an outpatient claim.  The
                                                         purpose of the count is to indicate how
                                                         many revenue center trailers are present.

                                                2 DIGITS UNSIGNED

                                                DB2 ALIAS: OP_REV_CNTR_CD_CNT
                                                SAS ALIAS: OPREVCNT
                                                STANDARD ALIAS: OP_REV_CNTR_CD_I_CNT

                                                EDIT-RULES:
                                                RANGE: 0 TO 45

                                                COMMENT:
                                                Prior to Version H this field was named:
```

```
                                  CLM_REV_CNTR_CD_CNT.

                                  NOTE:  During the Version 'I' conversion the
                                         number of occurrences changed to 45 (per
                                         segment - 450 total for claim).  For
                                         claims prior to Version 'I' the number of
                                         occurrences was 58, but in the conversion
                                         we made all claims back to service year
                                         1991 contain only 45 revenue center lines.
                                         It is possible that claims prior to 1991
                                         will have 2 segments if they contained
                                         more than 45 revenue lines.

                                  SOURCE:
                                  NCH

    62. Patient Discharge Status      CHAR    2  272 273  The code used to identify the status of the
        Code                                              patient as of the CLM_THRU_DT.

                                  COMMON ALIAS: DISCHARGE_DESTINATION/PATIENT_STATUS
                                  DB2 ALIAS: PTNT_DSCHRG_STUS
                                  SAS ALIAS: STUS_CD
                                  STANDARD ALIAS: PTNT_DSCHRG_STUS_CD
                                  SYSTEM ALIAS: LTCLMST
                                  TITLE ALIAS: PTNT_DSCHRG_STUS_CD

                                  CODES:
                                    REFER TO: PTNT_DSCHRG_STUS_TB
                                              IN THE CODES APPENDIX

                                  COMMENT:
                                  Prior to Version H this field was named:
                                  CLM_STUS_CD.

                                  SOURCE:
                                  CWF

1           FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

                                  POSITIONS
                  NAME           TYPE  LENGTH BEG  END                         CONTENTS
        -------------------------- ----  ------ --------  ------------------------------------------------------------

    63. Provider Number               CHAR    6  274 279  The identification number of the institutional provider
                                                          certified by Medicare to provide services to the
                                                          beneficiary.

                                  DB2 ALIAS: PRVDR_NUM
                                  SAS ALIAS: PROVIDER
                                  STANDARD ALIAS: PRVDR_NUM
                                  TITLE ALIAS: PROVIDER_NUMBER

                                  CODES:
                                    REFER TO: PRVDR_NUM_TB
                                              IN THE CODES APPENDIX

                                  SOURCE:
                                  OSCAR
```

```
   64.  HEADER-GRP.                    GROUP      50

       1. System-User                CHAR      30 278   309  A user-defined field that holds the description of the
                                                              request. For example, "Cross-referenced HICs".

       2. Filler                     CHAR      11 310   320  Filler

       3. Desy-Sort-Key              CHAR       9 321   329  This field contains the key to tie claims together for
                                                              one beneficiary regardless of HICAN.
```

```
        ********************************************************************************************

                    C L A I M    D I A G N O S I S    G R O U P    R E C O R D

        ********************************************************************************************


                                    POSITIONS
             NAME                TYPE  LENGTH BEG  END                        CONTENTS
        -------------------------  ----  ------ ---------  ------------------------------------------------------------

  ****  FI Outpatient Claim        GROUP   26              Claim Diagnosis Group Record
        Diagnosis Group                                    for the Encrypted Standard View of the
        Record - Encrypted                                 Outpatient Version I NCH Nearline File.
        Standard View

                                                           The number of claim diagnosis trailers is
                                                           determined by the claim diagnosis code
                                                           count.  The principal diagnosis is the first occurrence.
                                                           The 'E' code (ICD-9-CM code for the external cause
                                                           of an injury, poisoning, or adverse affect) is
                                                           stored as the last occurrence.
                                                           The principal diagnosis and the 'E' code are also
                                                           stored (redundantly) in the fixed record.

                                                           NOTE:
                                                           Prior to Version H this group was named:
                                                           CLM_OTHR_DGNS_GRP and did not contain the
                                                           CLM_PRNCPAL_DGNS_CD.

                                                           OCCURS: UP TO 10 TIMES
                                                                   DEPENDING ON OP_CLM_DGNS_CD_CNT

                                                           STANDARD ALIAS: UTLOUTPI_CLM_DGNS_GRP
```

```
    1. Record Length Count        NUM      5    1    5  The length of the Claim Diagnosis Group Record.

                                                        5 DIGITS UNSIGNED

                                                        STANDARD ALIAS: TRAIL_BYTE_COUNT

    2. Record Number              NUM      9    6   14  A sequentially assigned number for the claims included
                                                        in the file. This number allows the user to link all of
                                                        the records associated with one claim.

                                                        STANDARD ALIAS: TRAIL_CLAIM_NO

    3. Record Type                NUM      2   15   16  Type of Record.

                                                        STANDARD ALIAS: TRAIL_REC_TYPE

                                                        CODES:
                                                        00 = Fixed/Main Group
                                                        01 = Carrier Line Group
                                                        02 = Claim Demonstration ID Group
                                                        03 = Claim Diagnosis Group
                                                        04 = Claim Health PlanID Group
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                      POSITIONS
             NAME                TYPE  LENGTH BEG  END                        CONTENTS
    -------------------------    ----  ------ ---------  ------------------------------------------------------------

                                                        05 = Claim Occurrence Span Group
                                                        06 = Claim Procedure Group
                                                        07 = Claim Related Condition Group
                                                        08 = Claim Related Occurrence Group
                                                        09 = Claim Value Group
                                                        10 = MCO Period Group
                                                        11 = NCH Edit Group
                                                        12 = NCH Patch Group
                                                        13 = DMERC Line Group
                                                        14 = Revenue Center Group

    4. Claim Sequence Number      NUM      3   17   19  A counter for records that consist of trailer
                                                        information, such as claim line and revenue center
                                                        data, which can occur multiple times for one claim.

                                                        STANDARD ALIAS: TRAIL_CLAIM_SEQ

    5. NCH Claim Type Code        NUM      2   20   21  The code used to identify the type of claim record being
                                                        processed in NCH.

                                                        NOTE1:  During the Version H conversion this field was
                                                                populated with data through- out history (back to
                                                                service year 1991).

                                                        NOTE2:  During the Version I conversion this field was
                                                                expanded to include inpatient 'full' encounter
                                                                claims (for service dates after 6/30/97).
                                                                Placeholders for Physician and Outpatient encounters
                                                                (available in NMUD) have also been added.
```

```
                              STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD

                              DERIVATION:
                              FFS CLAIM TYPE CODES DERIVED FROM:
                                NCH CLM_NEAR_LINE_RIC_CD
                                NCH PMT_EDIT_RIC_CD
                                NCH CLM_TRANS_CD
                                NCH PRVDR_NUM

                              INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                (Pre-HDC processing -- AVAILABLE IN NCH)
                                CLM_MCO_PD_SW
                                CLM_RLT_COND_CD
                                MCO_CNTRCT_NUM

                                MCO_OPTN_CD
                                MCO_PRD_EFCTV_DT
                                MCO_PRD_TRMNTN_DT

                              INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                (HDC processing -- AVAILABLE IN NMUD)
                                FI_NUM
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                  POSITIONS
              NAME            TYPE  LENGTH BEG  END                      CONTENTS
    -------------------------- ----  ------ ---------  -----------------------------------------------------------

                              INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
                              FROM: (HDC processing -- AVAILABLE IN NMUD)
                                FI_NUM
                                CLM_FAC_TYPE_CD
                                CLM_SRVC_CLSFCTN_TYPE_CD
                                CLM_FREQ_CD
                              NOTE:  From 7/1/97 to the start of HDC processing(?),
                              abbreviated inpatient encounter claims are not
                              available in NCH or NMUD.

                              PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                (AVAILABLE IN NMUD)
                                CARR_NUM
                                CLM_DEMO_ID_NUM

                              OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                (AVAILABLE IN NMUD)
                                FI_NUM

                              OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
                              DERIVED FROM:  (AVAILABLE IN NMUD)
                                FI_NUM
                                CLM_FAC_TYPE_CD
                                CLM_SRVC_CLSFCTN_TYPE_CD
                                CLM_FREQ_CD

                              DERIVATION RULES:
```

```
                            SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
                            FOLLOWING CONDITIONS ARE MET:
                            1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
                            2.   PMT_EDIT_RIC_CD EQUAL 'F'
                            3.   CLM_TRANS_CD EQUAL '5'

                            SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
                            WHERE THE FOLLOWING CONDITIONS ARE MET:
                            1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                            2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                            3.   CLM_TRANS_CD EQUAL '0' OR '4'
                            4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
                                 OR 'Z'

                            SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
                            WHERE THE FOLLOWING CONDITIONS ARE MET:
                            1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                            2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'

                            3.   CLM_TRANS_CD EQUAL '0' OR '4'
                            4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
                                 OR 'Z'
```

```
                                     POSITIONS
            NAME                TYPE  LENGTH BEG  END                           CONTENTS
-------------------------       ----  ------ ---------   ------------------------------------------------------------
                            SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
                            WHERE THE FOLLOWING CONDITIONS ARE MET:
                            1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                            2.   PMT_EDIT_RIC_CD EQUAL 'D'
                            3.   CLM_TRANS_CD EQUAL '6'

                            SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
                            ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                            THE FOLLOWING CONDITIONS ARE MET:
                            1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                            2.   PMT_EDIT_RIC_CD EQUAL 'D'
                            3.   CLM_TRANS_CD EQUAL '6'
                            4.   FI_NUM = 80881

                            SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
                            ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
                            1.   FI_NUM = 80881
                            2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
                                 CLSFCTN_TYPE_CD = '2', '3' OR '4' &
                                 CLM_FREQ_CD = 'Z', 'Y' OR 'X'

                            SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
                            WHERE THE FOLLOWING CONDITIONS ARE MET:
                            1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                            2.   PMT_EDIT_RIC_CD EQUAL 'I'
                            3.   CLM_TRANS_CD EQUAL 'H'

                            SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
                            WHERE THE FOLLOWING CONDITIONS ARE MET:
```

```
                   1.    CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                   2.    PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                   3.    CLM_TRANS_CD EQUAL '1' '2' OR '3'

                   SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                   CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
                   12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
                   1.    CLM_MCO_PD_SW = '1'
                   2.    CLM_RLT_COND_CD = '04'
                   3.    MCO_CNTRCT_NUM
                         MCO_OPTN_CD = 'C'
                         CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
                         MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
                         ENROLLMENT PERIODS

                   SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                   CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
                   FOLLOWING CONDITIONS ARE MET:
                   1.    CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                   2.    PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                   3.    CLM_TRANS_CD EQUAL '1' '2' OR '3'
                   4.    FI_NUM = 80881
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                    POSITIONS
              NAME              TYPE  LENGTH BEG  END                              CONTENTS
   --------------------------   ----  ------ ---------  -----------------------------------------------------------

                   SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
                   ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                   THE FOLLOWING CONDITIONS ARE MET:
                   1.    FI_NUM = 80881 AND
                   2.    CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
                         TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

                   SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
                   WHERE THE FOLLOWING CONDITIONS ARE MET:
                   1.    CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                   2.    HCPCS_CD not on DMEPOS table

                   SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
                   WHERE THE FOLLOWING CONDITIONS ARE MET:
                   1.    CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                   2.    HCPCS_CD on DMEPOS table (NOTE: if one or
                           more line item(s) match the HCPCS on the
                           DMEPOS table).

                   SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
                   EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
                   CONDITIONS ARE MET:
                   1.    CARR_NUM = 80882 AND
                   2.    CLM_DEMO_ID_NUM = 38

                   SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
                       CLAIM)
                   WHERE THE FOLLOWING CONDITIONS ARE MET:
                   1.    CLM_NEAR_LINE_RIC_CD EQUAL 'M'
```

```
                                    2.   HCPCS_CD not on DMEPOS table

                               SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
                               WHERE THE FOLLOWING CONDITIONS ARE MET:
                               1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                               2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                      more line item(s) match the HCPCS on the
                                      DMEPOS table).

                               CODES:
                                REFER TO: NCH_CLM_TYPE_TB
                                            IN THE CODES APPENDIX

                               SOURCE:
                               NCH

    6. Claim Diagnosis Code        CHAR      5    22   26  The ICD-9-CM based code identifying the
                                                           beneficiary's principal or other diagnosis
                                                           (including E code).

                                                           NOTE:
                                                           Prior to Version H, the principal diagnosis
                                                           code was not stored with the 'OTHER' diagnosis
                                                           codes.  During the Version H conversion the
                                                           CLM_PRNCPAL_DGNS_CD was added as the first
                                                           occurrence.
1        FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002


                                     POSITIONS
              NAME             TYPE  LENGTH BEG  END                       CONTENTS
    -------------------------- ----  ------ ---------  ------------------------------------------------------------

                                                           DB2 ALIAS: CLM_DGNS_CD
                                                           SAS ALIAS: DGNS_CD
                                                           STANDARD ALIAS: CLM_DGNS_CD
                                                           TITLE ALIAS: DIAGNOSIS

                                                           EDIT-RULES:
                                                           ICD-9-CM

                                                           COMMENT:
                                                           Prior to Version H this field was named:
                                                           CLM_OTHR_DGNS_CD.

1        FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002


    *********************************************************************************************************
                  C L A I M    P R O C E D U R E    G R O U P    R E C O R D

    *********************************************************************************************************

                                     POSITIONS
              NAME             TYPE  LENGTH BEG  END                       CONTENTS
    -------------------------- ----  ------ ---------  ------------------------------------------------------------

  ****  FI Outpatient Claim        GROUP    33              Claim Procedure Group Record
```

```
        Procedure Group                         for the Encrypted Standard View of the
        Record - Encrypted                      Outpatient Version I Nearline File.
        Standard View


                                                The number of claim procedure trailers is
                                                determined by the claim procedure code
                                                count.  Prior to 10/93 up to 10 occurrences
                                                could be reported on an institutional claim.
                                                Beginning 10/93, up to six occurrences (one
                                                principal; five others) may be reported.

                                                OCCURS: UP TO 6 TIMES
                                                        DEPENDING ON OP_CLM_PRCDR_CD_CNT

                                                STANDARD ALIAS: UTLOUTPI_CLM_PRCDR_GRP



    1. Record Length Count        NUM      5    1    5  The length of the Claim Procedure Group Record.

                                                5 DIGITS UNSIGNED

                                                STANDARD ALIAS: TRAIL_BYTE_COUNT


    2. Record Number              NUM      9    6   14  A sequentially assigned number for the claims included
                                                in the file. This number allows the user to link all of
                                                the records associated with one claim.

                                                STANDARD ALIAS: TRAIL_CLAIM_NO


    3. Record Type                NUM      2   15   16  Type of Record.

                                                STANDARD ALIAS: TRAIL_REC_TYPE

                                                CODES:
                                                00 = Fixed/Main Group
                                                01 = Carrier Line Group
                                                02 = Claim Demonstration ID Group
                                                03 = Claim Diagnosis Group
                                                04 = Claim Health PlanID Group
                                                05 = Claim Occurrence Span Group
                                                06 = Claim Procedure Group
                                                07 = Claim Related Condition Group
                                                08 = Claim Related Occurrence Group
                                                09 = Claim Value Group
```

```
                                      POSITIONS
                NAME           TYPE  LENGTH BEG  END                        CONTENTS
        -------------------------- ---- ------ --------- ----------------------------------------------------------

                                                10 = MCO Period Group
                                                11 = NCH Edit Group
                                                12 = NCH Patch Group
                                                13 = DMERC Line Group
                                                14 = Revenue Center Group


    4. Claim Sequence Number      NUM      3   17   19  A counter for records that consist of trailer
                                                information, such as claim line and revenue center
```

data, which can occur multiple times for one claim.

STANDARD ALIAS: TRAIL_CLAIM_SEQ

```
   5. NCH Claim Type Code        CHAR    2   20  21  The code used to identify the type of claim record being
                                                      processed in NCH.
```

NOTE1: During the Version H conversion this field was
        populated with data through- out history (back to
        service year 1991).

NOTE2: During the Version I conversion this field was
        expanded to include inpatient 'full' encounter
        claims (for service dates after 6/30/97).
        Placeholders for Physician and Outpatient encounters
        (available in NMUD) have also been added.

STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD

DERIVATION:
FFS CLAIM TYPE CODES DERIVED FROM:
  NCH CLM_NEAR_LINE_RIC_CD
  NCH PMT_EDIT_RIC_CD
  NCH CLM_TRANS_CD
  NCH PRVDR_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (Pre-HDC processing -- AVAILABLE IN NCH)
  CLM_MCO_PD_SW
  CLM_RLT_COND_CD
  MCO_CNTRCT_NUM
  MCO_OPTN_CD
  MCO_PRD_EFCTV_DT
  MCO_PRD_TRMNTN_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (HDC processing -- AVAILABLE IN NMUD)
  FI_NUM

INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
FROM: (HDC processing -- AVAILABLE IN NMUD)
  FI_NUM
  CLM_FAC_TYPE_CD
  CLM_SRVC_CLSFCTN_TYPE_CD
  CLM_FREQ_CD

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                    POSITIONS
              NAME            TYPE  LENGTH BEG  END                           CONTENTS
     -------------------------  ----  ------ ---------  --------------------------------------------------------------
```

NOTE: From 7/1/97 to the start of HDC processing(?),
abbreviated inpatient encounter claims are not
available in NCH or NMUD.

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (AVAILABLE IN NMUD)

```
                    CARR_NUM
                    CLM_DEMO_ID_NUM

                  OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                    (AVAILABLE IN NMUD)
                    FI_NUM

                  OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
                  DERIVED FROM:  (AVAILABLE IN NMUD)
                    FI_NUM
                    CLM_FAC_TYPE_CD
                    CLM_SRVC_CLSFCTN_TYPE_CD
                    CLM_FREQ_CD

                  DERIVATION RULES:

                    SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
                    FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
                    2.   PMT_EDIT_RIC_CD EQUAL 'F'
                    3.   CLM_TRANS_CD EQUAL '5'

                    SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
                    WHERE THE FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                    2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                    3.   CLM_TRANS_CD EQUAL '0' OR '4'
                    4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
                         OR 'Z'

                    SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
                    WHERE THE FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                    2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                    3.   CLM_TRANS_CD EQUAL '0' OR '4'
                    4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
                         OR 'Z'

                    SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
                    WHERE THE FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                    2.   PMT_EDIT_RIC_CD EQUAL 'D'
                    3.   CLM_TRANS_CD EQUAL '6'

                    SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
                    ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                    THE FOLLOWING CONDITIONS ARE MET:
```

```
                                    POSITIONS
               NAME            TYPE  LENGTH BEG  END                              CONTENTS
     --------------------------  ----  ------ ---------  ------------------------------------------------------------
```

```
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                    2.   PMT_EDIT_RIC_CD EQUAL 'D'
                    3.   CLM_TRANS_CD EQUAL '6'
                    4.   FI_NUM = 80881
```

```
                         SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
                         ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
                         1.   FI_NUM = 80881
                         2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
                              CLSFCTN_TYPE_CD = '2', '3' OR '4' &
                              CLM_FREQ_CD = 'Z', 'Y' OR 'X'

                         SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
                         WHERE THE FOLLOWING CONDITIONS ARE MET:
                         1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                         2.   PMT_EDIT_RIC_CD EQUAL 'I'
                         3.   CLM_TRANS_CD EQUAL 'H'

                         SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
                         WHERE THE FOLLOWING CONDITIONS ARE MET:
                         1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                         2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                         3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

                         SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                         CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
                         12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
                         1.   CLM_MCO_PD_SW = '1'
                         2.   CLM_RLT_COND_CD = '04'
                         3.   MCO_CNTRCT_NUM
                              MCO_OPTN_CD = 'C'
                              CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
                              MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
                              ENROLLMENT PERIODS

                         SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                         CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
                         FOLLOWING CONDITIONS ARE MET:
                         1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                         2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                         3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'
                         4.   FI_NUM = 80881

                         SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
                         ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                         THE FOLLOWING CONDITIONS ARE MET:
                         1.   FI_NUM = 80881 AND
                         2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
                              TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

                         SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
                         WHERE THE FOLLOWING CONDITIONS ARE MET:
                         1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                         2.   HCPCS_CD not on DMEPOS table
```

```
                              POSITIONS
          NAME              TYPE  LENGTH BEG  END                              CONTENTS
------------------------- ---- ------ -------- ------------------------------------------------------------


                         SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
```

```
                                        WHERE THE FOLLOWING CONDITIONS ARE MET:
                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                                        2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                               more line item(s) match the HCPCS on the
                                               DMEPOS table).

                                        SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
                                        EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
                                        CONDITIONS ARE MET:
                                        1.   CARR_NUM = 80882 AND
                                        2.   CLM_DEMO_ID_NUM = 38

                                        SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
                                           CLAIM)
                                        WHERE THE FOLLOWING CONDITIONS ARE MET:
                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                        2.   HCPCS_CD not on DMEPOS table

                                        SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
                                        WHERE THE FOLLOWING CONDITIONS ARE MET:
                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                        2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                               more line item(s) match the HCPCS on the
                                               DMEPOS table).

                                        CODES:
                                          REFER TO: NCH_CLM_TYPE_TB
                                                    IN THE CODES APPENDIX

                                        SOURCE:
                                        NCH

                                        COMMENT:
                                        Prior to Version H this field was named:
                                        CLM_OTHR_DGNS_CD.

        6. Claim Procedure Code          CHAR      4   22   25   The ICD-9-CM code that indicates the principal or other
                                        procedure performed during the period covered by the
                                        institutional claim.

                                        DB2 ALIAS: CLM_PRCDR_CD
                                        SAS ALIAS: PRCDR_CD
                                        STANDARD ALIAS: CLM_PRCDR_CD
                                        TITLE ALIAS: PROCEDURE_CODE

                                        EDIT-RULES:
                                        ICD-9-CM

                                        SOURCE:
                                        CWF
```

```
                                  POSITIONS
            NAME                 TYPE  LENGTH BEG  END                              CONTENTS
   ------------------------      ----  ------ --------  ---------------------------------------------------------

   7. Claim Procedure Performed   NUM      8   26   33  On an institutional claim, the date on which
```

Date   the principal or other procedure was performed.

                                                   For the ENCRYPTED Standard View of the
                                                   Outpatient files, the claim procedure
                                                   performed date is coded as the quarter
                                                   of the calendar year when the procedure
                                                   was performed.

                                                   8 DIGITS UNSIGNED

                                                   DB2 ALIAS: CLM_PRCDR_PRFRM_DT
                                                   SAS ALIAS: PRCDR_DT
                                                   STANDARD ALIAS: CLM_PRCDR_PRFRM_DT
                                                   TITLE ALIAS: PROCEDURE_DATE

                                                   EDIT-RULES FOR ENCRYPTED DATA:
                                                   YYYYQ000 WHERE Q IS ONE OF THE
                                                   FOLLOWING VALUES.
                                                   1 = FIRST QUARTER OF THE CALENDAR YEAR
                                                   2 = SECOND QUARTER OF THE CALENDAR YEAR
                                                   3 = THIRD QUARTER OF THE CALENDAR YEAR
                                                   4 = FOURTH QUARTER OF THE CALENDAR YEAR

                                                   SOURCE:
                                                   CWF

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

      ****

                  C L A I M   R E L A T E D   C O N D I T I O N   G R O U P   R E C O R D

      ****

                                         POSITIONS
                NAME   TYPE LENGTH BEG END   CONTENTS
      -------------------------   ---- ------ ---------   --

 **** FI Outpatient Claim   GROUP   23   Claim Related Condition Group Record
       Related Condition Group   for the Encrypted Standard View of the
       Record - Encrypted   Outpatient version I NCH Nearline File.
       Standard View

                                                              The number of claim related condition
                                                              trailers is determined by the claim related
                                                              condition code count. Effective 10/93,
                                                              up to 30 occurrences can be reported on an
                                                              institutional claim. Prior to 10/93, up
                                                              to 10 occurrences could be reported.

                                                              OCCURS: UP TO 30 TIMES
                                                                      DEPENDING ON OP_CLM_RLT_COND_CD_CNT

                                                              STANDARD ALIAS: UTLOUTPI_CLM_RLT_COND_GRP

```
    1. Record Length Count        NUM     5    1    5  The length of the Claim Related Condition Group
                                                       Record.

                                                       5 DIGITS UNSIGNED

                                                       STANDARD ALIAS: TRAIL_BYTE_COUNT

    2. Record Number              NUM     9    6   14  A sequentially assigned number for the claims included
                                                       in the file. This number allows the user to link all of
                                                       the records associated with one claim.

                                                       STANDARD ALIAS: TRAIL_CLAIM_NO

    3. Record Type                NUM     2   15   16  Type of Record.

                                                       STANDARD ALIAS: TRAIL_REC_TYPE

                                                       CODES:
                                                       00 = Fixed/Main Group
                                                       01 = Carrier Line Group
                                                       02 = Claim Demonstration ID Group
                                                       03 = Claim Diagnosis Group
                                                       04 = Claim Health PlanID Group
                                                       05 = Claim Occurrence Span Group
                                                       06 = Claim Procedure Group
                                                       07 = Claim Related Condition Group
                                                       08 = Claim Related Occurrence Group
```

```
                                      POSITIONS
              NAME            TYPE  LENGTH BEG  END                          CONTENTS
    -------------------------  ----  ------ ---------  ------------------------------------------------------------

                                                       09 = Claim Value Group
                                                       10 = MCO Period Group
                                                       11 = NCH Edit Group
                                                       12 = NCH Patch Group
                                                       13 = DMERC Line Group
                                                       14 = Revenue Center Group

    4. Claim Sequence Number      NUM     3   17   19  A counter for records that consist of trailer
                                                       information, such as claim line and revenue center
                                                       data, which can occur multiple times for one claim.

                                                       STANDARD ALIAS: TRAIL_CLAIM_SEQ

    5. NCH Claim Type Code        CHAR    2   20   21  The code used to identify the type of claim record being
                                                       processed in NCH.

                                                       NOTE1:  During the Version H conversion this field was
                                                               populated with data through- out history (back to
                                                               service year 1991).

                                                       NOTE2:  During the Version I conversion this field was
                                                               expanded to include inpatient 'full' encounter
                                                               claims (for service dates after 6/30/97).
                                                               Placeholders for Physician and Outpatient encounters
```

(available in NMUD) have also been added.

                    STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD

                    DERIVATION:
                    FFS CLAIM TYPE CODES DERIVED FROM:
                      NCH CLM_NEAR_LINE_RIC_CD
                      NCH PMT_EDIT_RIC_CD
                      NCH CLM_TRANS_CD
                      NCH PRVDR_NUM

                    INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                      (Pre-HDC processing -- AVAILABLE IN NCH)
                      CLM_MCO_PD_SW
                      CLM_RLT_COND_CD
                      MCO_CNTRCT_NUM
                      MCO_OPTN_CD
                      MCO_PRD_EFCTV_DT
                      MCO_PRD_TRMNTN_DT

                    INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                      (HDC processing -- AVAILABLE IN NMUD)
                      FI_NUM

                    INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
                    FROM: (HDC processing -- AVAILABLE IN NMUD)
                      FI_NUM
                      CLM_FAC_TYPE_CD
                      CLM_SRVC_CLSFCTN_TYPE_CD
                      CLM_FREQ_CD

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

                                  POSITIONS
                NAME   TYPE LENGTH BEG END   CONTENTS
        ------------------------- ---- ------ --------- --
                                                      NOTE: From 7/1/97 to the start of HDC processing(?),
                                                      abbreviated inpatient encounter claims are not
                                                      available in NCH or NMUD.

                                                      PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                        (AVAILABLE IN NMUD)
                                                        CARR_NUM
                                                        CLM_DEMO_ID_NUM

                                                      OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                        (AVAILABLE IN NMUD)
                                                        FI_NUM

                                                      OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
                                                      DERIVED FROM: (AVAILABLE IN NMUD)
                                                        FI_NUM
                                                        CLM_FAC_TYPE_CD
                                                        CLM_SRVC_CLSFCTN_TYPE_CD
                                                        CLM_FREQ_CD

                                                      DERIVATION RULES:

```
                    SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
                    FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
                    2.   PMT_EDIT_RIC_CD EQUAL 'F'
                    3.   CLM_TRANS_CD EQUAL '5'

                    SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
                    WHERE THE FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                    2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                    3.   CLM_TRANS_CD EQUAL '0' OR '4'
                    4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
                         OR 'Z'

                    SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
                    WHERE THE FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                    2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                    3.   CLM_TRANS_CD EQUAL '0' OR '4'
                    4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
                         OR 'Z'

                    SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
                    WHERE THE FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                    2.   PMT_EDIT_RIC_CD EQUAL 'D'
                    3.   CLM_TRANS_CD EQUAL '6'

                    SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
                    ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                    THE FOLLOWING CONDITIONS ARE MET:
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                   POSITIONS
            NAME              TYPE LENGTH BEG  END                         CONTENTS
-------------------------     ---- ------ ---------   ------------------------------------------------------------
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                    2.   PMT_EDIT_RIC_CD EQUAL 'D'
                    3.   CLM_TRANS_CD EQUAL '6'
                    4.   FI_NUM = 80881

                    SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
                    ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
                    1.   FI_NUM = 80881
                    2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
                         CLSFCTN_TYPE_CD = '2', '3' OR '4' &
                         CLM_FREQ_CD = 'Z', 'Y' OR 'X'

                    SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
                    WHERE THE FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                    2.   PMT_EDIT_RIC_CD EQUAL 'I'
                    3.   CLM_TRANS_CD EQUAL 'H'

                    SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
```

WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_MCO_PD_SW = '1'
2.   CLM_RLT_COND_CD = '04'
3.   MCO_CNTRCT_NUM
      MCO_OPTN_CD = 'C'
      CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
      MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
      ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'
4.   FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1.   FI_NUM = 80881 AND
2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
      TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2.   HCPCS_CD not on DMEPOS table

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

                                    POSITIONS
                  NAME   TYPE LENGTH BEG END   CONTENTS
      -------------------------- ---- ------ --------- --

                                                    SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
                                                    WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                                                    2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                                          more line item(s) match the HCPCS on the
                                                          DMEPOS table).

                                                    SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
                                                    EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
                                                    CONDITIONS ARE MET:
                                                    1.   CARR_NUM = 80882 AND
                                                    2.   CLM_DEMO_ID_NUM = 38

                                                    SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
                                                       CLAIM)

```
                                 WHERE THE FOLLOWING CONDITIONS ARE MET:
                                 1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                 2.   HCPCS_CD not on DMEPOS table

                                 SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
                                 WHERE THE FOLLOWING CONDITIONS ARE MET:
                                 1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                 2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                        more line item(s) match the HCPCS on the
                                        DMEPOS table).

                                 CODES:
                                   REFER TO: NCH_CLM_TYPE_TB
                                             IN THE CODES APPENDIX

                                 SOURCE:
                                 NCH

                                 COMMENT:
                                 Prior to Version H this field was named:
                                 CLM_OTHR_DGNS_CD.

   6. Claim Related Condition    CHAR    2   22   23  The code that indicates a condition relating to
      Code                                             an institutional claim that may affect payer
                                                       processing.

                                 DB2 ALIAS: CLM_RLT_COND_CD
                                 SAS ALIAS: RLT_COND
                                 STANDARD ALIAS: CLM_RLT_COND_CD
                                 SYSTEM ALIAS: LTCOND
                                 TITLE ALIAS: RELATED_CONDITION_CD

                                 CODES:
                                 01 THRU 16 = Insurance related
                                 17 THRU 30 = Special condition
                                 31 THRU 35 = Student status codes which are required
                                                 when a patient is a dependent child
                                                 over 18 years old
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                        POSITIONS
                 NAME           TYPE  LENGTH BEG  END                       CONTENTS
      --------------------------  ----  ------ ---------  --------------------------------------------------------
```

```
                                 36 THRU 45 = Accommodation
                                 46 THRU 54 = CHAMPUS information
                                 55 THRU 59 = Skilled nursing facility
                                 60 THRU 70 = Prospective payment
                                 71 THRU 99 = Renal dialysis setting
                                 A0 THRU B9 = Special program codes
                                 C0 THRU C9 = PRO approval services
                                 D0 THRU W0 = Change conditions

                                 CODES:
                                   REFER TO: CLM_RLT_COND_TB
                                             IN THE CODES APPENDIX
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

   ****

            C L A I M   R E L A T E D   O C C U R R E N C E   G R O U P   R E C O R D

   ****

```
                              POSITIONS
              NAME            TYPE  LENGTH BEG   END                      CONTENTS
   -------------------------  ----  ------ ---------  ------------------------------------------------------------

**** FI Outpatient Claim     GROUP   31                Claim Related Occurrence Group Record
     Related Occurrence                                for the Encrypted Standard View of the
     Group Record -                                    Outpatient files version I
     Encrypted Standard                                NCH Nearline  File.
     View
                                                       The number of claim related occurrence
                                                       trailers is determined by the claim related
                                                       occurrence code count. Effective 10/93,
                                                       up to 30 occurrences can be reported on an
                                                       institutional claim. Prior to 10/93, up
                                                       to 10 occurrences could be reported.


                                                       OCCURS: UP TO 30 TIMES
                                                               DEPENDING ON OP_CLM_RLT_OCRNC_CD_CNT

                                                       STANDARD ALIAS: UTLOUTPI_CLM_RLT_OCRNC_GRP


  1. Record Length Count      NUM     5     1    5     The length of the Claim Related Occurrence Group
                                                       Record.

                                                       5 DIGITS UNSIGNED

                                                       STANDARD ALIAS: TRAIL_BYTE_COUNT

  2. Record Number            NUM     9     6   14     A sequentially assigned number for the claims included
                                                       in the file. This number allows the user to link all of
                                                       the records associated with one claim.

                                                       STANDARD ALIAS: TRAIL_CLAIM_NO

  3. Record Type              NUM     2    15   16     Type of Record.

                                                       STANDARD ALIAS: TRAIL_REC_TYPE

                                                       CODES:
                                                       00 = Fixed/Main Group
                                                       01 = Carrier Line Group
                                                       02 = Claim Demonstration ID Group
                                                       03 = Claim Diagnosis Group
                                                       04 = Claim Health PlanID Group
                                                       05 = Claim Occurrence Span Group
```

```
                                        06 = Claim Procedure Group
                                        07 = Claim Related Condition Group
                                        08 = Claim Related Occurrence Group
                                        09 = Claim Value Group


1        FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

                                 POSITIONS
                NAME            TYPE  LENGTH BEG  END                      CONTENTS
     --------------------------  ----  ------ --------  ------------------------------------------------------------

                                        10 = MCO Period Group
                                        11 = NCH Edit Group
                                        12 = NCH Patch Group
                                        13 = DMERC Line Group
                                        14 = Revenue Center Group

     4. Claim Sequence Number     NUM      3   17   19  A counter for records that consist of trailer
                                                        information, such as claim line and revenue center
                                                        data, which can occur multiple times for one claim.

                                                        STANDARD ALIAS: TRAIL_CLAIM_SEQ

     5. NCH Claim Type Code       CHAR     2   20   21  The code used to identify the type of claim record being
                                                        processed in NCH.

                                                        NOTE1:  During the Version H conversion this field was
                                                                populated with data through- out history (back to
                                                                service year 1991).

                                                        NOTE2:  During the Version I conversion this field was
                                                                expanded to include inpatient 'full' encounter
                                                                claims (for service dates after 6/30/97).
                                                                Placeholders for Physician and Outpatient encounters
                                                                (available in NMUD) have also been added.

                                                        STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD

                                                        DERIVATION:
                                                        FFS CLAIM TYPE CODES DERIVED FROM:
                                                          NCH CLM_NEAR_LINE_RIC_CD
                                                          NCH PMT_EDIT_RIC_CD
                                                          NCH CLM_TRANS_CD
                                                          NCH PRVDR_NUM

                                                        INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                          (Pre-HDC processing -- AVAILABLE IN NCH)
                                                          CLM_MCO_PD_SW
                                                          CLM_RLT_COND_CD
                                                          MCO_CNTRCT_NUM
                                                          MCO_OPTN_CD
                                                          MCO_PRD_EFCTV_DT
                                                          MCO_PRD_TRMNTN_DT

                                                        INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                          (HDC processing -- AVAILABLE IN NMUD)
                                                          FI_NUM
```

```
                                       INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
                                       FROM: (HDC processing -- AVAILABLE IN NMUD)
                                         FI_NUM
                                         CLM_FAC_TYPE_CD
                                         CLM_SRVC_CLSFCTN_TYPE_CD
                                         CLM_FREQ_CD
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                  POSITIONS
                NAME              TYPE  LENGTH BEG  END                              CONTENTS
-------------------------  ----  ------ ---------  ------------------------------------------------------------
                                                   NOTE:  From 7/1/97 to the start of HDC processing(?),
                                                   abbreviated inpatient encounter claims are not
                                                   available in NCH or NMUD.

                                                   PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                     (AVAILABLE IN NMUD)
                                                     CARR_NUM
                                                     CLM_DEMO_ID_NUM

                                                   OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                     (AVAILABLE IN NMUD)
                                                     FI_NUM

                                                   OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
                                                   DERIVED FROM:  (AVAILABLE IN NMUD)
                                                     FI_NUM
                                                     CLM_FAC_TYPE_CD
                                                     CLM_SRVC_CLSFCTN_TYPE_CD
                                                     CLM_FREQ_CD

                                                   DERIVATION RULES:

                                                     SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
                                                     FOLLOWING CONDITIONS ARE MET:
                                                     1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
                                                     2.   PMT_EDIT_RIC_CD EQUAL 'F'
                                                     3.   CLM_TRANS_CD EQUAL '5'

                                                     SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
                                                     WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                     1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                     2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                     3.   CLM_TRANS_CD EQUAL '0' OR '4'
                                                     4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
                                                          OR 'Z'

                                                     SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
                                                     WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                     1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                     2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                     3.   CLM_TRANS_CD EQUAL '0' OR '4'
                                                     4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
                                                          OR 'Z'

                                                     SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
```

```
                                    WHERE THE FOLLOWING CONDITIONS ARE MET:
                                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                                    2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                    3.   CLM_TRANS_CD EQUAL '6'
                                    SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
                                    ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                                    THE FOLLOWING CONDITIONS ARE MET:
                                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
```

```
                             POSITIONS
                NAME            TYPE  LENGTH BEG  END                          CONTENTS
        -------------------------  ----  ------ ---------  ----------------------------------------------------------
                                    2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                    3.   CLM_TRANS_CD EQUAL '6'
                                    4.   FI_NUM = 80881

                                    SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
                                    ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
                                    1.   FI_NUM = 80881
                                    2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
                                         CLSFCTN_TYPE_CD = '2', '3' OR '4' &
                                         CLM_FREQ_CD = 'Z', 'Y' OR 'X'

                                    SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
                                    WHERE THE FOLLOWING CONDITIONS ARE MET:
                                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                    2.   PMT_EDIT_RIC_CD EQUAL 'I'
                                    3.   CLM_TRANS_CD EQUAL 'H'

                                    SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
                                    WHERE THE FOLLOWING CONDITIONS ARE MET:
                                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                    2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                    3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

                                    SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                                    CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
                                    12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
                                    1.   CLM_MCO_PD_SW = '1'
                                    2.   CLM_RLT_COND_CD = '04'
                                    3.   MCO_CNTRCT_NUM
                                         MCO_OPTN_CD = 'C'
                                         CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
                                         MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
                                         ENROLLMENT PERIODS

                                    SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                                    CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
                                    FOLLOWING CONDITIONS ARE MET:
                                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                    2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                    3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'
                                    4.   FI_NUM = 80881

                                    SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
```

ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
THE FOLLOWING CONDITIONS ARE MET:
1.   FI_NUM = 80881 AND
2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
      TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2.   HCPCS_CD not on DMEPOS table

| | | | POSITIONS | |
NAME	TYPE	LENGTH	BEG END	CONTENTS

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2.   HCPCS_CD on DMEPOS table (NOTE: if one or
         more line item(s) match the HCPCS on the
         DMEPOS table).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
CONDITIONS ARE MET:
1.   CARR_NUM = 80882 AND
2.   CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
   CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2.   HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2.   HCPCS_CD on DMEPOS table (NOTE: if one or
         more line item(s) match the HCPCS on the
         DMEPOS table).

CODES:
  REFER TO: NCH_CLM_TYPE_TB
              IN THE CODES APPENDIX

SOURCE:
NCH

COMMENT:
Prior to Version H this field was named:
CLM_OTHR_DGNS_CD.

| 6. Claim Related Occurrence Code | CHAR | 2 | 22 23 | The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are |

```
                                             claim-related occurrences that are related
                                             to a specific date.

                                             DB2 ALIAS: CLM_RLT_OCRNC_CD
                                             SAS ALIAS: OCRNC_CD
                                             STANDARD ALIAS: CLM_RLT_OCRNC_CD
                                             SYSTEM ALIAS: LTOCRNC
                                             TITLE ALIAS: OCCURRENCE_CD

                                             CODES:
                                             01 THRU 09 = Accident
                                             10 THRU 19 = Medical condition
                                             20 THRU 39 = Insurance related
```

```
                                POSITIONS
              NAME          TYPE  LENGTH BEG  END                          CONTENTS
    -------------------------  ----  ------ --------  --------------------------------------------------------

                                             40 THRU 69 = Service related
                                             A1-A3 = Miscellaneous

                                             CODES:
                                                REFER TO: CLM_RLT_OCRNC_TB
                                                          IN THE CODES APPENDIX

                                             SOURCE:
                                             CWF

     7. Claim Related Occurrence  NUM     8    24   31  The date associated with a significant event
        Date                                           related to an institutional claim that may
                                                       affect payer processing.

                                             For the ENCRYPTED Standard View of the
                                             Outpatient files, the claim procedure
                                             performed date is coded as the quarter
                                             of the calendar year when the procedure
                                             was performed.

                                             8 DIGITS UNSIGNED

                                             DB2 ALIAS: CLM_RLT_OCRNC_DT
                                             SAS ALIAS: OCRNCDT
                                             STANDARD ALIAS: CLM_RLT_OCRNC_DT
                                             TITLE ALIAS: RLT_OCRNC_DT

                                             EDIT-RULES FOR ENCRYPTED DATA:
                                             YYYYQ000 WHERE Q IS ONE OF THE
                                             FOLLOWING VALUES.
                                             1 = FIRST QUARTER OF THE CALENDAR YEAR
                                             2 = SECOND QUARTER OF THE CALENDAR YEAR
                                             3 = THIRD QUARTER OF THE CALENDAR YEAR
                                             4 = FOURTH QUARTER OF THE CALENDAR YEAR

                                             SOURCE:
                                             CWF
```

```
  *******************************************************************************

                 C L A I M    V A L U E    G R O U P    R E C O R D

  *******************************************************************************

                                       POSITIONS
                   NAME           TYPE LENGTH BEG  END                    CONTENTS
          -------------------     ---- ------ ---------  ------------------------------------------------------
****  FI Outpatient Claim        GROUP   36             Claim Value Code Group Record
      Value Group Record -                              for the Encrypted Standard View of the
      Encrypted Standard View                           Outpatient version I NCH Nearline File.


                                                        The number of claim value data trailers
                                                        present is determined by the claim
                                                        value code count. Effective 10/93,
                                                        up to 36 occurrences can be reported on an
                                                        institutional claim. Prior to 10/93, up
                                                        to 10 occurrences could be reported.


                                                        OCCURS: UP TO 36 TIMES
                                                                DEPENDING ON OP_CLM_VAL_CD_CNT

                                                        STANDARD ALIAS: UTLOUTPI_CLM_VAL_GRP


      1. Record Length Count     NUM     5    1    5   The length of the Claim Value Code Group Record.

                                                        5 DIGITS UNSIGNED

                                                        STANDARD ALIAS: TRAIL_BYTE_COUNT

      2. Record Number           NUM     9    6   14   A sequentially assigned number for the claims included
                                                        in the file. This number allows the user to link all of
                                                        the records associated with one claim.

                                                        STANDARD ALIAS: TRAIL_CLAIM_NO

      3. Record Type             NUM     2   15   16   Type of Record.

                                                        STANDARD ALIAS: TRAIL_REC_TYPE

                                                        CODES:
                                                        00 = Fixed/Main Group
                                                        01 = Carrier Line Group
                                                        02 = Claim Demonstration ID Group
                                                        03 = Claim Diagnosis Group
                                                        04 = Claim Health PlanID Group
                                                        05 = Claim Occurrence Span Group
                                                        06 = Claim Procedure Group
                                                        07 = Claim Related Condition Group
                                                        08 = Claim Related Occurrence Group
                                                        09 = Claim Value Group
```

```
                                          POSITIONS
               NAME             TYPE  LENGTH BEG  END                      CONTENTS
     -------------------------- ---- ------ ---------  ------------------------------------------------------------
                                                      10 = MCO Period Group
                                                      11 = NCH Edit Group
                                                      12 = NCH Patch Group
                                                      13 = DMERC Line Group
                                                      14 = Revenue Center Group

     4. Claim Sequence Number    NUM     3    17   19 A counter for records that consist of trailer
                                                      information, such as claim line and revenue center
                                                      data, which can occur multiple times for one claim.

                                                      STANDARD ALIAS: TRAIL_CLAIM_SEQ

     5. NCH Claim Type Code      CHAR    2    20   21 The code used to identify the type of claim record being
                                                      processed in NCH.

                                                      NOTE1:  During the Version H conversion this field was
                                                              populated with data through- out history (back to
                                                              service year 1991).

                                                      NOTE2:  During the Version I conversion this field was
                                                              expanded to include inpatient 'full' encounter
                                                              claims (for service dates after 6/30/97).
                                                              Placeholders for Physician and Outpatient encounters
                                                              (available in NMUD) have also been added.

                                                      SYSTEM ALIAS: TRAIL_NCH_CLM_TYPE_CD

                                                      DERIVATION:
                                                      FFS CLAIM TYPE CODES DERIVED FROM:
                                                        NCH CLM_NEAR_LINE_RIC_CD
                                                        NCH PMT_EDIT_RIC_CD
                                                        NCH CLM_TRANS_CD
                                                        NCH PRVDR_NUM

                                                      INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                        (Pre-HDC processing -- AVAILABLE IN NCH)
                                                        CLM_MCO_PD_SW
                                                        CLM_RLT_COND_CD
                                                        MCO_CNTRCT_NUM
                                                        MCO_OPTN_CD
                                                        MCO_PRD_EFCTV_DT
                                                        MCO_PRD_TRMNTN_DT

                                                      INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                        (HDC processing -- AVAILABLE IN NMUD)
                                                        FI_NUM

                                                      INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
                                                      FROM: (HDC processing -- AVAILABLE IN NMUD)
                                                        FI_NUM
                                                        CLM_FAC_TYPE_CD
```

```
                        CLM_SRVC_CLSFCTN_TYPE_CD
                        CLM_FREQ_CD
```

```
                                   POSITIONS
              NAME              TYPE LENGTH BEG  END                          CONTENTS
-------------------------       ---- ------ ---------   -------------------------------------------------------------
                                                        NOTE:  From 7/1/97 to the start of HDC processing(?),
                                                        abbreviated inpatient encounter claims are not
                                                        available in NCH or NMUD.

                                                        PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                          (AVAILABLE IN NMUD)
                                                          CARR_NUM
                                                          CLM_DEMO_ID_NUM

                                                        OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                          (AVAILABLE IN NMUD)
                                                          FI_NUM

                                                        OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
                                                        DERIVED FROM:  (AVAILABLE IN NMUD)
                                                          FI_NUM
                                                          CLM_FAC_TYPE_CD
                                                          CLM_SRVC_CLSFCTN_TYPE_CD
                                                          CLM_FREQ_CD

                                                        DERIVATION RULES:

                                                          SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
                                                          FOLLOWING CONDITIONS ARE MET:
                                                          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
                                                          2.   PMT_EDIT_RIC_CD EQUAL 'F'
                                                          3.   CLM_TRANS_CD EQUAL '5'

                                                          SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
                                                          WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                          2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                          3.   CLM_TRANS_CD EQUAL '0' OR '4'
                                                          4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
                                                               OR 'Z'

                                                          SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
                                                          WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                          2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                          3.   CLM_TRANS_CD EQUAL '0' OR '4'
                                                          4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
                                                               OR 'Z'

                                                          SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
                                                          WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                                                          2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                                          3.   CLM_TRANS_CD EQUAL '6'
```

```
                                           POSITIONS
               NAME                TYPE  LENGTH BEG  END                          CONTENTS
    --------------------------     ----  ------ --------  -------------------------------------------------------------
```

                                                 SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
                                                 ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                                                 THE FOLLOWING CONDITIONS ARE MET:

                                                 1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                                                 2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                                 3.   CLM_TRANS_CD EQUAL '6'
                                                 4.   FI_NUM = 80881

                                                 SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
                                                 ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
                                                 1.   FI_NUM = 80881
                                                 2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
                                                      CLSFCTN_TYPE_CD = '2', '3' OR '4' &
                                                      CLM_FREQ_CD = 'Z', 'Y' OR 'X'

                                                 SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
                                                 WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                 1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                 2.   PMT_EDIT_RIC_CD EQUAL 'I'
                                                 3.   CLM_TRANS_CD EQUAL 'H'

                                                 SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
                                                 WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                 1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                 2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                 3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

                                                 SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                                                 CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
                                                 12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                 1.   CLM_MCO_PD_SW = '1'
                                                 2.   CLM_RLT_COND_CD = '04'
                                                 3.   MCO_CNTRCT_NUM
                                                      MCO_OPTN_CD = 'C'
                                                      CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
                                                      MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
                                                      ENROLLMENT PERIODS

                                                 SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                                                 CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
                                                 FOLLOWING CONDITIONS ARE MET:
                                                 1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                 2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                 3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'
                                                 4.   FI_NUM = 80881

                                                 SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
                                                 ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                                                 THE FOLLOWING CONDITIONS ARE MET:
                                                 1.   FI_NUM = 80881 AND

```
                                          2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
                                               TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

                                          SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
                                          WHERE THE FOLLOWING CONDITIONS ARE MET:
                                          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                                          2.   HCPCS_CD not on DMEPOS table
```

```
                                POSITIONS
           NAME              TYPE  LENGTH BEG  END                           CONTENTS
-------------------------    ----  ------ ---------  -------------------------------------------------------------
                                          SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
                                          WHERE THE FOLLOWING CONDITIONS ARE MET:
                                          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                                          2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                               more line item(s) match the HCPCS on the
                                               DMEPOS table).

                                          SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
                                          EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
                                          CONDITIONS ARE MET:
                                          1.   CARR_NUM = 80882 AND
                                          2.   CLM_DEMO_ID_NUM = 38

                                          SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
                                             CLAIM)
                                          WHERE THE FOLLOWING CONDITIONS ARE MET:
                                          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                          2.   HCPCS_CD not on DMEPOS table

                                          SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
                                          WHERE THE FOLLOWING CONDITIONS ARE MET:
                                          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                          2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                               more line item(s) match the HCPCS on the
                                               DMEPOS table).

                                          CODES:
                                            REFER TO: NCH_CLM_TYPE_TB
                                                       IN THE CODES APPENDIX

                                          SOURCE:
                                          NCH


                                          COMMENT:
                                          Prior to Version H this field was named:
                                          CLM_OTHR_DGNS_CD.

  6. Claim Value Code          CHAR    2    22   23  The code indicating the value of a monetary
                                                     condition which was used by the intermediary
                                                     to process an institutional claim.

                                                     DB2 ALIAS: CLM_VAL_CD
                                                     SAS ALIAS: VAL_CD
```

```
                               STANDARD ALIAS: CLM_VAL_CD
                               SYSTEM ALIAS: LTVALUE
                               TITLE ALIAS: VALUE_CD

                               CODES:
                                 REFER TO: CLM_VAL_TB
                                            IN THE CODES APPENDIX

                               SOURCE:
                               CWF
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                   POSITIONS
                  NAME          TYPE  LENGTH BEG  END                          CONTENTS
      -------------------------  ----  ------ ---------  ------------------------------------------------------------

      7. Claim Value Amount        CHAR   13   24   36  The amount related to the condition identified
                                                        in the CLM_VAL_CD which was used by the
                                                        intermediary to process the institutional
                                                        claim.

                                                        9.2 DIGITS SIGNED

                                                        DB2 ALIAS: CLM_VAL_AMT
                                                        SAS ALIAS: VAL_AMT
                                                        STANDARD ALIAS: CLM_VAL_AMT
                                                        TITLE ALIAS: VALUE_AMOUNT

                                                        EDIT-RULES:
                                                        +9(9).99

                                                        SOURCE:
                                                        CWF
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
      **********************************************************************************************************

              C L A I M    R E V E N U E    C E N T E R    G R O U P    R E C O R D

      **********************************************************************************************************

                                   POSITIONS
                  NAME          TYPE  LENGTH BEG  END                          CONTENTS
      -------------------------  ----  ------ ---------  ------------------------------------------------------------

   ****  FI Outpatient Claim      GROUP   262             Claim Revenue Center Group Record
         Revenue Center Group                             for the Encrypted Standard View of the
         Record - Encrypted                               Outpatient version I Nearline File.
         Standard View

                                                          The number of claim revenue center group
                                                          trailers present is determined by the claim
                                                          revenue center code count. Effective 7/7/00,
                                                          up to 450 occurrences may be reported for an
                                                          institutional claim. The increase in the number
```

of revenue center lines causes each claim to
be broken out into records/segments (up to 10).
Each record can have up to 45 occurrences of
revenue center lines. Prior to 7/7/00, up to
58 occurrences may be reported on an institutional
claim. Claims submitted prior to 10/93, contained
up to 28 occurrences.

OCCURS: UP TO 45 TIMES
          DEPENDING ON OP_REV_CNTR_CD_I_CNT

STANDARD ALIAS: UTLOUTPI_CLM_REV_CNTR_GRP

COMMENT:
****************** FOR SNF PPS *********************
The Balanced Budget Act modified how payment will be
made for skilled nursing facility (SNF) services.
Effective with cost reporting periods beginning on or
after 7/1/98 (with all providers transitioning by
6/30/99, SNFs will be paid on a prospective payment
system (PPS).

SNFs will classify beneficiaries on the basis of
residents' characteristics and resource needs, using
the 44-group patient classification system known as
Resource Utilization Groups (RUGS), Version III.
Facilities will use information from the Minimum Data
Set (MDS), Version 2.0, Resident Assessment Instrument
(RAI) to classify residents into the RUG-III groups.

***************** FOR OUTPATIENT PPS ***************
The Balanced Budget Act modified how payment will be
made for hospital outpatient services, certain PTB
services furnished to inpatients who have no PTA
coverage, CMHCs, and limited services provided by
CORFs, Home Health Agencies or to hospice patients
for the treatment of a non-terminal illness. Imple-

```
                                        POSITIONS
            NAME                TYPE  LENGTH BEG   END                              CONTENTS
-------------------------    ----  ------ --------   ------------------------------------------------------------
```

mentation for Outpatient PPS (OPPS) will be effective
for claims with dates of service on or after
July 1, 2000.

Payment for services under the OPPS system is
calculated based on grouping outpatient services
into ambulatory payment classifications (APC) groups.

************** FOR HOME HEALTH PPS ***************
The Balanced Budget Act of 1997 mandated changes in
payment and other provider requirements for home
health. All home health agencies will be paid
through a prospective payment system beginning
October 1, 2000.

Under Home Health PPS (HH PPS) the unit of payment
will be a 60-day episode. Home Health Resources
Groups (HHRGs), also called HRGs represented by
HCFA HIPPS coding, will be the basis of payment for
each episode; HHRGs will be produced through pubicly
available Grouper software that will determine the
appropriate HHRG when results of comprehensive
assessments of the beneficiary (made incorporating
the OASIS data set) are input or grouped in this
software.

1. Record Length Count   NUM   5   1   5   The length of the Claim Revenue Center Group
                                                       Record.

                                                       5 DIGITS UNSIGNED

                                                       STANDARD ALIAS: TRAIL_BYTE_COUNT

2. Record Number   NUM   9   6   14   An automatically assigned number for the claims included
                                                       in the file. This number allows the user to link all of
                                                       the records associated with one claim.

                                                       STANDARD ALIAS: TRAIL_CLAIM_NO

3. Record Type   NUM   2   15   16   Type of Record.

                                                       STANDARD ALIAS: TRAIL_REC_TYPE

                                                       CODES:
                                                       00 = Fixed/Main Group
                                                       01 = Carrier Line Group
                                                       02 = Claim Demonstration ID Group
                                                       03 = Claim Diagnosis Group
                                                       04 = Claim Health PlanID Group
                                                       05 = Claim Occurrence Span Group
                                                       06 = Claim Procedure Group
                                                       07 = Claim Related Condition Group

| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS

                                                       08 = Claim Related Occurrence Group
                                                       09 = Claim Value Group
                                                       10 = MCO Period Group
                                                       11 = NCH Edit Group
                                                       12 = NCH Patch Group
                                                       13 = DMERC Line Group
                                                       14 = Revenue Center Group

4. Claim Sequence Number   NUM   3   17   19   A counter for records that consist of trailer
                                                       information, such as claim line and revenue center
                                                       data, which can occur multiple times for one claim.

                                                       STANDARD ALIAS: TRAIL_CLAIM_SEQ

```
   5. NCH Claim Type Code        CHAR    2   20  21  The code used to identify the type of claim record being
                                                     processed in NCH.

                                                     NOTE1:  During the Version H conversion this field was
                                                             populated with data through- out history (back to
                                                             service year 1991).

                                                     NOTE2:  During the Version I conversion this field was
                                                             expanded to include inpatient 'full' encounter
                                                             claims (for service dates after 6/30/97).
                                                             Placeholders for Physician and Outpatient encounters
                                                             (available in NMUD) have also been added.

                                                     STANDARD ALIAS: TRAIL_NCH_CLM_TYPE_CD

                                                     DERIVATION:
                                                     FFS CLAIM TYPE CODES DERIVED FROM:
                                                       NCH CLM_NEAR_LINE_RIC_CD
                                                       NCH PMT_EDIT_RIC_CD
                                                       NCH CLM_TRANS_CD
                                                       NCH PRVDR_NUM

                                                     INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                       (Pre-HDC processing -- AVAILABLE IN NCH)
                                                       CLM_MCO_PD_SW
                                                       CLM_RLT_COND_CD
                                                       MCO_CNTRCT_NUM
                                                       MCO_OPTN_CD
                                                       MCO_PRD_EFCTV_DT
                                                       MCO_PRD_TRMNTN_DT

                                                     INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                       (HDC processing -- AVAILABLE IN NMUD)
                                                       FI_NUM

                                                     INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
                                                     FROM: (HDC processing -- AVAILABLE IN NMUD)

1       FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

                                        POSITIONS
                 NAME           TYPE  LENGTH BEG  END                            CONTENTS
        -------------------------  ----  ------ ---------  -------------------------------------------------------------

                                                     FI_NUM
                                                     CLM_FAC_TYPE_CD
                                                     CLM_SRVC_CLSFCTN_TYPE_CD
                                                     CLM_FREQ_CD
                                                     NOTE:  From 7/1/97 to the start of HDC processing(?),
                                                     abbreviated inpatient encounter claims are not
                                                     available in NCH or NMUD.

                                                     PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                       (AVAILABLE IN NMUD)
                                                       CARR_NUM
                                                       CLM_DEMO_ID_NUM
```

```
                    OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                      (AVAILABLE IN NMUD)
                      FI_NUM

                    OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
                    DERIVED FROM:  (AVAILABLE IN NMUD)
                      FI_NUM
                      CLM_FAC_TYPE_CD
                      CLM_SRVC_CLSFCTN_TYPE_CD
                      CLM_FREQ_CD

                    DERIVATION RULES:

                      SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
                      FOLLOWING CONDITIONS ARE MET:
                      1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
                      2.   PMT_EDIT_RIC_CD EQUAL 'F'
                      3.   CLM_TRANS_CD EQUAL '5'

                      SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
                      WHERE THE FOLLOWING CONDITIONS ARE MET:
                      1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                      2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                      3.   CLM_TRANS_CD EQUAL '0' OR '4'
                      4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
                           OR 'Z'

                      SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
                      WHERE THE FOLLOWING CONDITIONS ARE MET:
                      1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                      2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                      3.   CLM_TRANS_CD EQUAL '0' OR '4'
                      4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
                           OR 'Z'

                      SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
                      WHERE THE FOLLOWING CONDITIONS ARE MET:
                      1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                      2.   PMT_EDIT_RIC_CD EQUAL 'D'
                      3.   CLM_TRANS_CD EQUAL '6'
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                              POSITIONS
               NAME            TYPE  LENGTH BEG  END                          CONTENTS
    -------------------------- ----  ------ --------  -------------------------------------------------------------
```

```
                    SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
                    ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                    THE FOLLOWING CONDITIONS ARE MET:
                    1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                    2.   PMT_EDIT_RIC_CD EQUAL 'D'
                    3.   CLM_TRANS_CD EQUAL '6'
                    4.   FI_NUM = 80881

                    SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
                    ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
                    1.   FI_NUM = 80881
```

```
              2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
                   CLSFCTN_TYPE_CD = '2', '3' OR '4' &
                   CLM_FREQ_CD = 'Z', 'Y' OR 'X'

              SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
              WHERE THE FOLLOWING CONDITIONS ARE MET:
              1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
              2.   PMT_EDIT_RIC_CD EQUAL 'I'
              3.   CLM_TRANS_CD EQUAL 'H'

              SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
              WHERE THE FOLLOWING CONDITIONS ARE MET:
              1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
              2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
              3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

              SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
              CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
              12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
              1.   CLM_MCO_PD_SW = '1'
              2.   CLM_RLT_COND_CD = '04'
              3.   MCO_CNTRCT_NUM
                   MCO_OPTN_CD = 'C'
                   CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
                   MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
                   ENROLLMENT PERIODS

              SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
              CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
              FOLLOWING CONDITIONS ARE MET:
              1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
              2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
              3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'
              4.   FI_NUM = 80881

              SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
              ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
              THE FOLLOWING CONDITIONS ARE MET:
              1.   FI_NUM = 80881 AND
              2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
                   TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

              SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
```

```
                                 POSITIONS
            NAME              TYPE  LENGTH BEG  END                              CONTENTS
-------------------------     ----  ------ ---------  -------------------------------------------------------------

                              WHERE THE FOLLOWING CONDITIONS ARE MET:
                              1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                              2.   HCPCS_CD not on DMEPOS table

                              SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
                              WHERE THE FOLLOWING CONDITIONS ARE MET:
                              1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                              2.   HCPCS_CD on DMEPOS table (NOTE: if one or
```

```
                          more line item(s) match the HCPCS on the
                          DMEPOS table).

                          SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
                          EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
                          CONDITIONS ARE MET:
                          1.   CARR_NUM = 80882 AND
                          2.   CLM_DEMO_ID_NUM = 38

                          SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
                             CLAIM)
                          WHERE THE FOLLOWING CONDITIONS ARE MET:
                          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                          2.   HCPCS_CD not on DMEPOS table

                          SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
                          WHERE THE FOLLOWING CONDITIONS ARE MET:
                          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                          2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                 more line item(s) match the HCPCS on the
                                 DMEPOS table).

                          CODES:
                            REFER TO: NCH_CLM_TYPE_TB
                                      IN THE CODES APPENDIX

                          SOURCE:
                          NCH

                          COMMENT:
                          Prior to Version H this field was named:
                          CLM_OTHR_DGNS_CD.

6. Revenue Center Code        CHAR    4   22   25   The provider-assigned revenue code for each cost center for
                                                    which a separate charge is billed (type of accommodation or
                                                    ancillary).  A cost center is a division or unit within a
                                                    hospital (e.g., radiology, emergency room, pathology).

                                                    EXCEPTION:  Revenue center code 0001 represents the total of
                                                    all revenue centers included on the claim.

                                                    COBOL ALIAS: REV_CD
                                                    DB2 ALIAS: REV_CNTR_CD
                                                    SAS ALIAS: REV_CNTR
                                                    STANDARD ALIAS: REV_CNTR_CD
```

```
                              POSITIONS
                NAME          TYPE  LENGTH BEG  END                              CONTENTS
  -------------------------- ---- ------ --------- ------------------------------------------------------------

                                                    SYSTEM ALIAS: LTRC
                                                    TITLE ALIAS: REVENUE_CENTER_CD

                                                    CODES:
                                                      REFER TO: REV_CNTR_TB
                                                                IN THE CODES APPENDIX
```

```
  7. Revenue Center Date       NUM      8   26   33   Effective with Version H, the date applicable
                                                      to the service represented by the revenue center
                                                      code.   This field may be present on any of the
                                                      institutional claim types.  For home health claims
                                                      the service date should be present on all bills
                                                      with from date greater than 3/31/98.  With the
                                                      implementation of outpatient PPS, hospitals will
                                                      be required to enter line item dates of service
                                                      for all outpatient services which require a HCPCS.

                                                      For the ENCRYPTED Standard View of the Outpatient
                                                      files, the date applicable to the service
                                                      represented by the revenue center code is
                                                      coded as the quarter of the calendar year
                                                      when the service represented by the revenue
                                                      center code occurred.

                                                      NOTE1:  Beginning with NCH weekly process date
                                                      10/3/97 this field was populated with data.
                                                      Claims processed prior to 10/3/97 will contain
                                                      zeroes in this field.

                                                      NOTE2:  When revenue center code equals '0022'
                                                      (SNF PPS) and revenue center HCPCS code not equal
                                                      to 'AAA00' (default for no assessment), date re-
                                                      presents the MDS RAI assessment reference date.

                                                      NOTE3:  When revenue center code equals '0023'
                                                      (HHPPS), the  date on the initial claim (RAP) must
                                                      represent the first date of service in the episode.
                                                      The final claim will match the '0023' information
                                                      submitted on the initial claim.  The SCIC
                                                      (significant change in condition) claims may show
                                                      additional '0023' revenue lines in which the
                                                      date represents the date of the first service
                                                      under the revised plan of treatment.

                                                      8 DIGITS UNSIGNED

                                                      DB2 ALIAS: REV_CNTR_DT
                                                      SAS ALIAS: REV_DT
                                                      STANDARD ALIAS: REV_CNTR_DT
                                                      TITLE ALIAS: REV_CNTR_DATE
```

```
                                POSITIONS
                  NAME          TYPE  LENGTH BEG  END                              CONTENTS
         -------------------------- ----  ------ ---------  -----------------------------------------------------------

                                                      EDIT-RULES FOR ENCRYPTED DATA:
                                                      YYYYQ000 WHERE Q IS ONE OF THE
                                                      FOLLOWING VALUES.
                                                      1 = FIRST QUARTER OF THE CALENDAR YEAR
```

```
                                              2 = SECOND QUARTER OF THE CALENDAR YEAR
                                              3 = THIRD QUARTER OF THE CALENDAR YEAR
                                              4 = FOURTH QUARTER OF THE CALENDAR YEAR

                                              SOURCE:
                                              CWF

  8. Revenue Center APC/HIPPS   CHAR    5   34  38   Effective with Outpatient PPS (OPPS), the Ambulatory
     Code                                           Payment Classification (APC) code used to identify
                                                    groupings of outpatient services.  APC codes are
                                                    used to calculate payment for services under
                                                    OPPS.

                                              Effective with Home Health PPS (HHPPS), this field
                                              will only be populated with a HIPPS code if the HIPPS
                                              code that is stored in the HCPCS field has been
                                              downcoded and the new code will be placed in this
                                              field.

                                              NOTE1: Under SNF PPS and HHPPS, HIPPS codes are
                                              stored in the HCPCS field. **EXCEPTION: if a
                                              HHPPS HIPPS code is downcoded the downcoded
                                              HIPPS will be stored in this field.

                                              NOTE2:  Beginning with NCH weekly process date
                                              8/18/00, this field will be populated with data.
                                              Claims processed prior to 8/18/00 will contain
                                              spaces in this field.

                                              DB2 ALIAS: REV_APC_HIPPS_CD
                                              SAS ALIAS: APCHIPPS
                                              STANDARD ALIAS: REV_CNTR_APC_HIPPS_CD
                                              SYSTEM ALIAS: LTAPC
                                              TITLE ALIAS: APC_HIPPS

                                              CODES:
                                                REFER TO: REV_CNTR_APC_TB
                                                          IN THE CODES APPENDIX

                                              SOURCE:
                                              CWF

  9. Revenue Center HCFA Common  CHAR   5   39  43   HCFA's Common Procedure Coding System (HCPCS)
     Procedure Coding System                        is a collection of codes that represent procedures,
     Code                                           supplies, products and services which may be
                                                    provided to Medicare beneficiaries and to
                                                    individuals enrolled in private health
                                                    insurance programs.  The codes are divided
                                                    into three levels, or groups, as described
                                                    below:
```

```
                                       POSITIONS
              NAME              TYPE  LENGTH BEG  END                          CONTENTS
   -------------------------    ----  ------ --------   --------------------------------------------------------------
```

```
                                              DB2 ALIAS: REV_CNTR_HCPCS_CD
```

```
SAS ALIAS: HCPCS_CD
STANDARD ALIAS: REV_CNTR_HCPCS_CD
SYSTEM ALIAS: LTHIPPS
TITLE ALIAS: HCPCS_CD

CODES:
  REFER TO: CLM_HIPPS_TB
            IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
HCPCS_CD.  With Version H, a prefix
was added to denote the location of this field
on each claim type (institutional: REV_CNTR and
non-institutional: LINE).

NOTE:  When revenue center code = '0022' (SNF PPS)
or '0023' (HH PPS), this field contains the Health
Insurance PPS (HIPPS) code.  The HIPPS code for
SNF PPS contains the rate code/assessment type that
identifies (1) RUG-III group the beneficiary was
classified into as of the RAI MDS assessment reference
date and (2) the type of assessment for payment pur-
poses.

The HIPPS code for Home Health PPS identifies
(1) the three case-mix dimensions of the HHRG system,
clinical, functional and utilization, from which a
beneficiary is assigned to one of the 80 HHRG
categories and (2) it identifies whether or not
the elements of the code were computed or derived.
The HHRGs, represented by the HIPPS coding, will be
the basis of payment for each episode.

For both SNF PPS & HH PPS HIPPS values see CLM_HIPPS_TB.

Level I
   Codes and descriptors copyrighted by the American
   Medical Association's Current Procedural
   Terminology, Fourth Edition (CPT-4).  These are
   5 position numeric codes representing physician
   and nonphysician services.

   **** Note: ****
   CPT-4 codes including both long and short
   descriptions shall be used in accordance with the
   HCFA/AMA agreement.  Any other use violates the
   AMA copyright.

Level II
   Includes codes and descriptors copyrighted by
   the American Dental Association's Current Dental
```

```
                               POSITIONS
           NAME            TYPE  LENGTH BEG  END                         CONTENTS
-------------------------  ----  ------ --------  -------------------------------------------------------------
```

Terminology, Second Edition (CDT-2). These are
5 position alpha-numeric codes comprising
the D series. All other level II codes and
descriptors are approved and maintained jointly
by the alpha-numeric editorial panel (consisting
of HCFA, the Health Insurance Association of
America, and the Blue Cross and Blue Shield
Association). These are 5 position alpha-
numeric codes representing primarily items and
nonphysician services that are not
represented in the level I codes.

Level III
   Codes and descriptors developed by Medicare
carriers for use at the local (carrier) level.
These are 5 position alpha-numeric codes in the
W, X, Y or Z series representing physician
and nonphysician services that are not
represented in the level I or level II codes.

10. Revenue Center HCPCS   CHAR   2   44 45   A first modifier to the procedure code to enable a more
    Initial Modifier Code   specific procedure identification for the claim.

                                            DB2 ALIAS: REV_HCPCS_MDFR_CD
                                            SAS ALIAS: MDFR_CD1
                                          STANDARD ALIAS: REV_CNTR_HCPCS_INITL_MDFR_CD
                                          TITLE ALIAS: INITIAL_MODIFIER

                                          EDIT-RULES:
                                          Carrier Information File

                                          COMMENT:
                                          Prior to Version H this field was named:
                                          HCPCS_INITL_MDFR_CD. With Version H, a prefix
                                          was added to denote the location of this field
                                          on each claim type (institutional: REV_CNTR and
                                          non-institutional: LINE).

                                          SOURCE:
                                          CWF

11. Revenue Center HCPCS Second CHAR   2   46 47   A second modifier to the procedure code to make it more
    Modifier Code   specific than the first modifier code to identify the
                                          procedures performed on the beneficiary for the claim.

                                          DB2 ALIAS: REV_HCPCS_2ND_CD
                                          SAS ALIAS: MDFR_CD2
                                          STANDARD ALIAS: REV_CNTR_HCPCS_2ND_MDFR_CD
                                          TITLE ALIAS: SECOND_MODIFIER

                                          EDIT-RULES:
                                          CARRIER INFORMATION FILE

                                  POSITIONS
          NAME   TYPE LENGTH BEG END   CONTENTS

```
-------------------------  ----  ------ ---------  -------------------------------------------------------------
                                                   COMMENT:
                                                   Prior to Version H this field was named:
                                                   HCPCS_2ND_MDFR_CD.  With Version H, a prefix
                                                   was added to denote the location of this field
                                                   on each claim type (institutional: REV_CNTR and
                                                   non-institutional: LINE).

                                                   SOURCE:
                                                   CWF

12. Revenue Center HCPCS Third   CHAR    2    48   49   Effective with Version I, a third modifier to the
    Modifier Code                                        procedure code to make  it more specific than the
                                                         second modifier code to identify the procedures
                                                         performed on the beneficiary for the claim.

                                                   DB2 ALIAS: REV_HCPCS_3RD_CD
                                                   SAS ALIAS: MDFR_CD3
                                                   STANDARD ALIAS: REV_CNTR_HCPCS_3RD_MDFR_CD
                                                   TITLE ALIAS: THIRD_MODIFIER

                                                   EDIT-RULES:
                                                   CARRIER INFORMATION FILE

                                                   COMMENT:
                                                   NOTE:  Beginning with NCH weekly process date
                                                   8/18/00, this field will be populated with data.
                                                   Claims processed prior to 8/18/00 will contain
                                                   spaces in this field.

                                                   SOURCE:
                                                   CWF

13. Revenue Center HCPCS Fourth   CHAR    2    50   51   Effective with Version I, a fourth modifier to the
    Modifier Code                                        procedure code to make it more specific than the
                                                         third modifier code to identify the procedures
                                                         performed on the beneficiary for the claim.

                                                   DB2 ALIAS: REV_HCPCS_4TH_CD
                                                   SAS ALIAS: MDFR_CD4
                                                   STANDARD ALIAS: REV_CNTR_HCPCS_4TH_MDFR_CD
                                                   TITLE ALIAS: FOURTH_MODIFIER

                                                   EDIT-RULES:
                                                   CARRIER INFORMATION FILE

                                                   COMMENT:
                                                   NOTE:  Beginning with NCH weekly process date
                                                   8/18/00, this field will be populated with data.
                                                   Claims processed prior to 8/18/00 will contain
                                                   spaces in this field.

                                                   SOURCE:
                                                   CWF
```

```
                            POSITIONS
          NAME          TYPE  LENGTH BEG  END                       CONTENTS
------------------------- ----  ------ ---------  ------------------------------------------------------------

14. Revenue Center HCPCS Fifth  CHAR    2    52   53   Effective with Version I, a fifth modifier to the
    Modifier Code                                      procedure code to make it more specific than the
                                                       fourth modifier code to identify the procedures
                                                       performed on the beneficiary for the claim.

                                                       DB2 ALIAS: REV_HCPCS_5TH_CD
                                                       SAS ALIAS: MDFR_CD5
                                                       STANDARD ALIAS: REV_CNTR_HCPCS_5TH_MDFR_CD
                                                       TITLE ALIAS: FIFTH_MODIFIER

                                                       EDIT-RULES:
                                                       CARRIER INFORMATION FILE

                                                       COMMENT:
                                                       NOTE:  Beginning with NCH weekly process date
                                                       8/18/00, this field will be populated with data.
                                                       Claims processed prior to 8/18/00 will contain
                                                       spaces in this field.

                                                       SOURCE:
                                                       CWF

15. Revenue Center Payment      CHAR    2    54   55   Effective with Version 'I', the code used to
    Method Indicator Code                              identify how the service is priced for payment.
                                                       This field is made up of two pieces of data,
                                                       1st position being the service indicator and
                                                       the 2nd position being the payment indicator.

                                                       NOTE:  Beginning with NCH weekly process date
                                                       8/18/00, this field will be populated with data.
                                                       Claims processed prior to 8/18/00 will contain
                                                       spaces in this field.

                                                       DB2 ALIAS: REV_PMT_MTHD_CD
                                                       SAS ALIAS: PMTMTHD
                                                       STANDARD ALIAS: REV_CNTR_PMT_MTHD_IND_CD
                                                       SYSTEM ALIAS: LTPMTHD
                                                       TITLE ALIAS: PMT_MTHD

                                                       CODES:
                                                         REFER TO: REV_CNTR_PMT_MTHD_IND_TB
                                                                   IN THE CODES APPENDIX

                                                       SOURCE:
                                                       CWF

16. Revenue Center Discount     CHAR    1    56   56   Effective with Version 'I', for all services
    Indicator Code                                     subject to Outpatient PPS, this code represents
                                                       a factor that specifies the amount of any APC
                                                       discount.  The discounting factor is applied
                                                       to a line item with a service indicator (part
                                                       of the REV_CNTR_PMT_MTHD_IND_CD) of 'T'.  The
                                                       flag is applicable when more than one significant
                                                       procedure is performed. **If there is no dis-
```

```
                                               POSITIONS
                     NAME             TYPE  LENGTH BEG  END                        CONTENTS
            -------------------------  ----  ------ --------- ---------------------------------------------------------
```

NOTE1: Beginning with NCH weekly process date
8/18/00, this field will be populated with data.
Claims processed prior to 8/18/00 will contain
spaces in this field.

DB2 ALIAS: REV_DSCNT_IND_CD
SAS ALIAS: DSCNTIND
STANDARD ALIAS: REV_CNTR_DSCNT_IND_CD
SYSTEM ALIAS: LTDSCNT
TITLE ALIAS: REV_CNTR_DSCNT_IND_CD

CODES:
DISCOUNTING FORMULAS
1 = 1.0
2 = (1.0+D(U-1))/U
3 = T/U
4 = (1+D)/U
5 = D
6 = TD/U
7 = D(1+D)/U
8 = 2.0/U

SOURCE:
CWF

17. Revenue Center Packaging   CHAR   1   57 57   Effective with Version 'I', for all services
    Indicator Code   subject to Outpatient PPS, the code used to
                                                        identify those services that are packaged/
                                                        bundled with another service.

NOTE: Beginning with NCH weekly process date
8/18/00, this field will be populated with data.
Claims processed prior to 8/18/00 will contain
spaces in this field.

DB2 ALIAS: REV_PACKG_IND_CD
SAS ALIAS: PACKGIND
STANDARD ALIAS: REV_CNTR_PACKG_IND_CD
SYSTEM ALIAS: LTPACKG
TITLE ALIAS: REV_CNTR_PACKG_IND

CODES:
0 = Not packaged
1 = Packaged service (service indicator N)
2 = Packaged as part of partial hospitalization
    per diem or daily mental health service
    per diem

SOURCE:
CWF

```
   18. Revenue Center Pricing      CHAR    2   58  59  Effective with Version 'I', the code used
       Indicator Code                                  to identify if there was a deviation from
1          FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

                                         POSITIONS
                  NAME           TYPE  LENGTH BEG  END                       CONTENTS
       -------------------------  ----  ------ ---------  ----------------------------------------------------------
                                                          the standard method of calculating payment
                                                          amount.

                                                          NOTE:  Beginning with NCH weekly process date
                                                          8/18/00, this field will be populated with data.
                                                          Claims processed prior to 8/18/00 will contain
                                                          spaces in this field.

                                                          DB2 ALIAS: REV_PRICNG_IND_CD
                                                          SAS ALIAS: PRICNG
                                                          STANDARD ALIAS: REV_CNTR_PRICNG_IND_CD
                                                          SYSTEM ALIAS: LTPRICNG
                                                          TITLE ALIAS: REV_CNTR_PRICNG_IND

                                                          CODES:
                                                            REFER TO: REV_CNTR_PRICNG_IND_TB
                                                                      IN THE CODES APPENDIX

                                                          SOURCE:
                                                          CWF

   19. Revenue Center Obligation  CHAR    1   60  60  Effective with Version 'I' the code used
       to Accept As Full (OTAF)                         to indicate that the provider was obligated
       Payment Code                                     to accept as full payment the amount re-
                                                        ceived from the primary (or secondary) payer.

                                                          NOTE:  Beginning with NCH weekly process date
                                                          7/7/00, this field will be populated with data.
                                                          Claims processed prior to 7/7/00 will contain
                                                          spaces in this field.

                                                          DB2 ALIAS: REV_OTAF1_IND_CD
                                                          SAS ALIAS: OTAF_1
                                                          STANDARD ALIAS: REV_CNTR_OTAF_1_IND_CD
                                                          TITLE ALIAS: REV_CNTR_OTAF_1_IND_CD

                                                          EDIT-RULES:
                                                          Y = provider is obligated to accept the payment
                                                              as payment in full for the service.
                                                          N or blank  = provider is not obligated to accept
                                                              the payment, or there is no payment by a prior
                                                              payer.

                                                          SOURCE:
                                                          CWF

   20. Revenue Center IDE, NDC,   CHAR   24   61  84  Effective with Version H, the exemption number
       UPC Number                                       assigned by the Food and Drug Administration (FDA)
                                                        to an investigational device after a manufacturer
```

has been approved by FDA to conduct a clinical
trial on that device.   CMS established a new
policy of covering certain IDE's which was
implemented in claims processing on 10/1/96
(which is NCH weekly process 10/4/96) for service

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                       POSITIONS
            NAME              TYPE  LENGTH BEG  END                          CONTENTS
--------------------------    ----  ------ ---------  -------------------------------------------------------------
```

dates beginning 10/1/95. IDE's are always
associated with revenue center code '0624'.

NOTE1: Prior to Version H a 'dummy' revenue
center code '0624' trailer was created to store
IDE's.   The IDE number was housed in two fields:
HCPCS code and HCPCS initial modifier; the second
modifier contained the value 'ID'. There can be
up to 7 distinct IDE numbers associated with an
'0624' dummy trailer. During the Version H con-
version IDE's were moved from the dummy '0624'
trailer to this dedicated field.

NOTE2: Effective with Version 'I', this field was
renamed to eventually accommodate the National Drug Code
(NDC) and the Universal Product Code (UPC). This field
could contain either of these 3 fields (there would never
be an instance where more than one would come in on
a claim). The size of this field was expanded to X(24)
to accommodate either of the new fields (under Version
'H' it was X(7). DATA ANAMOLY/LIMITATION: During an
CWFMQA review an edit revealed the IDE was missing.
The problem occurs in claim with an NCH weekly pro-
cess dates of 6/9/00 through 9/8/00. During processing
of the new format the program receives the IDE but
then blanked out the data.

DB2 ALIAS: IDE_NDC_UPC_NUM
SAS ALIAS: IDENDC
STANDARD ALIAS: REV_CNTR_IDE_NDC_UPC_NUM
TITLE ALIAS: IDE_NDC_UPC

SOURCE:
CWF

21. Revenue Center Unit Count   CHAR   8   85   92 A quantitative measure (unit) of the number of times the
service or procedure being reported was performed according
to the revenue center/HCPCS code definition as described on
an institutional claim.

Depending on type of service, units are measured by number
of covered days in a particular accommodation, pints of
blood, emergency room visits, clinic visits, dialysis
treatments (sessions or days), outpatient therapy visits,
and outpatient clinical diagnostic laboratory tests.

NOTE1: When revenue center code = '0022' (SNF PPS) the unit
count will reflect the number of covered days for each HIPPS
code and, if applicable, the number of visits for each rehab
therapy code.

7 DIGITS SIGNED

```
                                      POSITIONS
                NAME            TYPE  LENGTH BEG  END                              CONTENTS
      --------------------------  ----  ------ ---------  --------------------------------------------------------
                                                          DB2 ALIAS: REV_CNTR_UNIT_CNT
                                                          SAS ALIAS: REV_UNIT
                                                          STANDARD ALIAS: REV_CNTR_UNIT_CNT
                                                          TITLE ALIAS: UNITS

                                                          EDIT-RULES:
                                                          +9(7)

                                                          SOURCE:
                                                          CWF

      22. Revenue Center Rate Amount   CHAR   13    93  105  Charges relating to unit cost associated with
                                                          the revenue center code.  Exception (encounter
                                                          data only):  If plan (e.g. MCO) does not know
                                                          the actual rate for the accommodations, $1 will
                                                          be reported in the field.
```

NOTE1: For SNF PPS claims (when revenue center
code equals '0022'), HCFA has developed a SNF
PRICER to compute the rate based on the provider
supplied coding for the MDS RUGS III group and
assessment type (HIPPS code, stored in revenue
center HCPCS code field).

NOTE2: For OP PPS claims, HCFA has developed a
PRICER to compute the rate based on the Ambulatory
Payment Classification (APC), discount factor,
units of service and the wage index.

NOTE3: Under HH PPS (when revenue center
code equals '0023'), HCFA has developed a HHA
PRICER to compute the rate. On the RAP, the rate is
determined using the case mix weight associated with
the HIPPS code, adjusting it for the wage index
for the beneficiary's site of service, then
multiplying the result by 60% or 50%, depending on
whether or not the RAP is for a first episode.

On the final claim, the HIPPS code could change the
payment if the therapy threshold is not met, or
partial episode payment (PEP) adjustment or a
significant change in condition (SCIC) adjustment.
In cases of SCICs, there will be more than one
'0023' revenue center line, each representing the
payment made at each case-mix level.

```
                               9.2 DIGITS SIGNED

                               DB2 ALIAS: REV_CNTR_RATE_AMT
                               SAS ALIAS: REV_RATE
                               STANDARD ALIAS: REV_CNTR_RATE_AMT
                               TITLE ALIAS: CHARGE_PER_UNIT
```

```
                                POSITIONS
          NAME          TYPE  LENGTH BEG  END                        CONTENTS
------------------------- ----  ------ ---------  -----------------------------------------------------------
                                             EDIT-RULES:
                                             +9(9).99

                                             EFFECTIVE-DATE: 10/01/1993

                                             COMMENT:
                                             Prior to Version H the size of this field was:
                                             S9(7)V99.

                                             SOURCE:
                                             CWF

  23. Revenue Center Blood    CHAR   13   106  118  Effective with Version 'I', the amount of money
      Deductible Amount                             for which the intermediary determined the
                                                    beneficiary is liable for the blood deductible
                                                    for the line item service.

                                                    NOTE:  Beginning with NCH weekly process date
                                                    7/7/00, this field will be populated with data.
                                                    Claims processed prior to 7/7/00 will contain
                                                    spaces in this field.

                                                    9.2 DIGITS SIGNED

                                                    DB2 ALIAS: REV_BLOOD_DDCTBL
                                                    SAS ALIAS: REVBLOOD
                                                    STANDARD ALIAS: REV_CNTR_BLOOD_DDCTBL_AMT
                                                    TITLE ALIAS: BLOOD_DDCTBL_AMT

                                                    EDIT-RULES:
                                                    +9(9).99

                                                    SOURCE:
                                                    CWF

  24. Revenue Center Cash     CHAR   13   119  131  Effective with Version 'I' the amount of cash
      Deductible Amount                             deductible the beneficiary paid for the line
                                                    item service.

                                                    NOTE:  Beginning with NCH weekly process date
                                                    7/7/00, this field will be populated with data.
                                                    Claims processed prior to 7/7/00 will contain
                                                    spaces in this field.
```

```
                                9.2 DIGITS SIGNED

                                DB2 ALIAS: REV_CASH_DDCTBL
                                SAS ALIAS: REVDCTBL
                                STANDARD ALIAS: REV_CNTR_CASH_DDCTBL_AMT
                                TITLE ALIAS: CASH_DDCTBL

                                EDIT-RULES:
                                +9(9).99
```

```
                                POSITIONS
            NAME              TYPE  LENGTH BEG  END                    CONTENTS
    -------------------------- ----  ------ --------- ------------------------------------------------------------

                                                 SOURCE:
                                                 CWF

25. Revenue Center            CHAR   13   132  144   Effective with Version 'I', the amount of
    Coinsurance/Wage Adjusted                        coinsurance applicable to the line item
    Coinsurance Amount                               service defined by the revenue center and
                                                     HCPCS codes.  For those services subject to
                                                     Outpatient PPS, the applicable coinsurance
                                                     is wage adjusted.

                                                     NOTE1:  This field will have either a zero
                                                     (for services for which coinsurance is not
                                                     applicable), a regular coinsurance amount
                                                     (calculated on either charges or a fee
                                                     schedule) or if subject to OP PPS the national
                                                     coinsurance amount will be wage adjusted.
                                                     The wage adjusted coinsurance is based on the
                                                     MSA where the provider is located or assigned
                                                     as a result of a reclassification.

                                                     NOTE2:  Beginning with NCH weekly process date
                                                     8/18/00, this field will be populated with data.
                                                     Claims processed prior to 8/18/00 will contain
                                                     spaces in this field.

                                                     9.2 DIGITS SIGNED

                                                     DB2 ALIAS: ADJSTD_COINSRNC
                                                     SAS ALIAS: WAGEADJ
                                                     STANDARD ALIAS: REV_CNTR_WAGE_ADJSTD_COINS_AMT
                                                     TITLE ALIAS: WAGE_ADJSTD_COINS

                                                     EDIT-RULES:
                                                     +9(9).99

                                                     SOURCE:
                                                     CWF

26. Revenue Center Reduced    CHAR   13   145  157   Effective with Version 'I', for all services
    Coinsurance Amount                               subject to Outpatient PPS, the amount of
                                                     coinsurance applicable to the line for a
                                                     particular service (HCPCS) for which the
```

provider has elected to reduce the coinsurance
amount.

NOTE1: The reduced coinsurance amount cannot
be lower than 20% of the payment rate for the
APC line.

NOTE2: Beginning with NCH weekly process date
8/18/00, this field will be populated with data.
Claims processed prior to 8/18/00 will contain
spaces in this field.

```
                                    POSITIONS
             NAME             TYPE  LENGTH BEG  END                          CONTENTS
   -------------------------- ----  ------ ---------  -----------------------------------------------------------
```

					9.2 DIGITS SIGNED
					DB2 ALIAS: RDCD_COINSRNC
					SAS ALIAS: RDCDCOIN
					STANDARD ALIAS: REV_CNTR_RDCD_COINS_AMT
					TITLE ALIAS: REDUCED_COINS
					EDIT-RULES: +9(9).99
					SOURCE: CWF
27. Revenue Center 1st Medicare Secondary Payer Paid Amount	CHAR	13	158	170	Effective with Version 'I', the amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary or tertiary). NOTE: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field. 9.2 DIGITS SIGNED DB2 ALIAS: REV_MSP1_PD_AMT SAS ALIAS: REV_MSP1 STANDARD ALIAS: REV_CNTR_MSP1_PD_AMT TITLE ALIAS: MSP PAID AMOUNT EDIT-RULES: +9(9).99 SOURCE: CWF
28. Revenue Center 2nd Medicare Secondary Payer Paid Amount	CHAR	13	171	183	Effective with Version 'I', the amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer). NOTE: Beginning with NCH weekly process date

7/7/00, this field will be populated with data.
Claims processed prior to 7/7/00 will contain
spaces in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: REV_MSP2_PD_AMT
SAS ALIAS: REV_MSP2
STANDARD ALIAS: REV_CNTR_MSP2_PD_AMT
TITLE ALIAS: MSP PAID AMOUNT

EDIT-RULES:
+9(9).99

```
                                POSITIONS
            NAME              TYPE  LENGTH BEG  END                          CONTENTS
------------------------      ----  ------ ---------   ------------------------------------------------------------
```

SOURCE:
CWF

29. Revenue Center Provider   CHAR   13   184 196   Effective with Version 'I', the amount paid
    Payment Amount   to the provider for the services reported
                                                        on the line item.

                                                        NOTE: Beginning with NCH weekly process date
                                                        7/7/00, this field will be populated with data.
                                                        Claims processed prior to 7/7/00 will contain
                                                        spaces in this field.

                                                        9.2 DIGITS SIGNED

                                                        DB2 ALIAS: REV_PRVDR_PMT_AMT
                                                        SAS ALIAS: RPRVDPMT
                                                        STANDARD ALIAS: REV_CNTR_PRVDR_PMT_AMT
                                                        TITLE ALIAS: REV_PRVDR_PMT

                                                        EDIT-RULES:
                                                        +9(9).99

                                                        SOURCE:
                                                        CWF

30. Revenue Center Beneficiary   CHAR   13   197 209   Effective with Version I, the amount paid
    Payment Amount   to the beneficiary for the services reported
                                                        on the line item.

                                                        NOTE: Beginning with NCH weekly process date
                                                        7/7/00, this field will be populated with data.
                                                        Claims processed prior to 7/7/00 will contain
                                                        spaces in this field.

                                                        9.2 DIGITS SIGNED

                                                        DB2 ALIAS: REV_BENE_PMT_AMT
                                                        SAS ALIAS: RBENEPMT

```
                                   STANDARD ALIAS: REV_CNTR_BENE_PMT_AMT
                                   TITLE ALIAS: REV_BENE_PMT

                                   EDIT-RULES:
                                   +9(9).99

                                   SOURCE:
                                   CWF

    31. Revenue Center Patient      CHAR   13   210  222   Effective with Version I, the amount paid
        Responsibility Payment                             by the beneficiary to the provider for the
        Amount                                             line item service.

                                                           NOTE:  Beginning with NCH weekly process date
                                                           7/7/00 this field was populated with data.
```

```
                                          POSITIONS
                    NAME             TYPE  LENGTH BEG  END                      CONTENTS
         --------------------------  ----  ------ ---------  ------------------------------------------------------------

                                                           Claims processed prior to 7/7/00 will contain
                                                           zeroes in this field.

                                                           9.2 DIGITS SIGNED

                                                           DB2 ALIAS: REV_PTNT_RESP_AMT
                                                           SAS ALIAS: PTNTRESP
                                                           STANDARD ALIAS: REV_CNTR_PTNT_RESP_PMT_AMT
                                                           TITLE ALIAS: REV_PTNT_RESP

                                                           EDIT-RULES:
                                                           +9(9).99

                                                           SOURCE:
                                                           CWF

    32. Revenue Center Payment       CHAR   13   223  235   Effective with Version 'I', the line item
        Amount                                             Medicare payment amount for the specific
                                                           revenue center.

                                                           Under OP PPS, PRICER will compute the
                                                           standard OPPS payment for a line item based
                                                           on the payment APC.

                                                           Under HH PPS, PRICER will compute/return
                                                           a line item payment amount for the case-mixed,
                                                           wage-index adjusted HIPPS code assigned to
                                                           the '0023' revenue center line.  The HIPPS
                                                           code will be stored in the Revenue Center
                                                           HCPCS code field.

                                                           9.2 DIGITS SIGNED

                                                           COMMON ALIAS: REIMBURSEMENT
                                                           DB2 ALIAS: REV_CNTR_PMT_AMT
                                                           SAS ALIAS: REVPMT
```

```
                                           STANDARD ALIAS: REV_CNTR_PMT_AMT
                                           TITLE ALIAS: REIMBURSEMENT

                                           EDIT-RULES:
                                           +9(9).99

                                           SOURCE:
                                           CWF

  33. Revenue Center Total Charge   CHAR   13   236  248   The total charges (covered and non-covered) for all
      Amount                                                accommodations and services (related to the revenue code)
                                                            for a billing period before reduction for the deductible and
                                                            coinsurance amounts and before an adjustment for the cost of
                                                            services provided.  NOTE: For accommodation revenue center
                                                            total charges must equal the rate times units (days).
```

```
                                        POSITIONS
                NAME               TYPE  LENGTH BEG  END                           CONTENTS
     --------------------------    ----  ------ ---------   ----------------------------------------------------------

                                                          EXCEPTIONS:
                                                          (1)  For SNF RUGS demo claims only (9000 series revenue
                                                          center codes), this field contains SNF customary
                                                          accommodation charge, (ie., charges related to the
                                                          accommodation revenue center code that would have been
                                                          applicable if the provider had not been participating in the
                                                          demo).

                                                          (2)  For SNF PPS (non demo claims), when revenue center code
                                                          = '0022', the total charges will be zero.

                                                          (3)  For Home Health PPS (RAPs), when revenue center code =
                                                          '0023', the total charges will equal the dollar amount for
                                                          the '0023' line.

                                                          (4) For Home Health PPS (final claim), when revenue center
                                                          code = '0023', the total charges will be the sum of the
                                                          revenue center code lines (other than '0023').

                                                          (5)  For encounter data, if the plan (e.g. MCO) does not
                                                          know the actual charges for the accommodations the total
                                                          charges will be $1 (rate) times units (days).

                                                          9.2 DIGITS SIGNED

                                                          DB2 ALIAS: REV_TOT_CHRG_AMT
                                                          SAS ALIAS: REV_CHRG
                                                          STANDARD ALIAS: REV_CNTR_TOT_CHRG_AMT
                                                          TITLE ALIAS: REVENUE_CENTER_CHARGES

                                                          EDIT-RULES:
                                                          +9(9).99

                                                          COMMENT:
                                                          Prior to Version H the size of this field was:
                                                          S9(7)V99.
```

```
                              SOURCE:
                              CWF

34. Revenue Center Non-Covered    CHAR   13  249  261   The charge amount related to a revenue center code for
    Charge Amount                                       services that are not covered by Medicare.

                                                        NOTE:  Prior to Version H the field size was S9(7)V99 and
                                                        the element was only present on the Inpatient/SNF format.
                                                        As of NCH weekly process date 10/3/97 this field was added
                                                        to all institutional claim types.

                                                        9.2 DIGITS SIGNED

                                                        DB2 ALIAS: REV_NCVR_CHRG_AMT
                                                        SAS ALIAS: REV_NCVR
                                                        STANDARD ALIAS: REV_CNTR_NCVR_CHRG_AMT
                                                        TITLE ALIAS: REV_CENTER_NONCOVERED_CHARGES
```

1   FI Outpatient Claim Record - Encrypted Standard View -- FROM CMS DATA DICTIONARY -- 06/2002

```
                                 POSITIONS
            NAME                TYPE  LENGTH BEG  END                          CONTENTS
 -------------------------      ----  ------ ---------  -------------------------------------------------------------

                                                        EDIT-RULES:
                                                        +9(9).99

                                                        SOURCE:
                                                        CWF

35. Revenue Center Deductible    CHAR    1   262  262   Code indicating whether the revenue center charges
    Coinsurance Code                                    are subject to deductible and/or coinsurance.

                                                        DB2 ALIAS: DDCTBL_COINSRNC_CD
                                                        SAS ALIAS: REVDEDCD
                                                        STANDARD ALIAS: REV_CNTR_DDCTBL_COINSRNC_CD
                                                        TITLE ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD

                                                        CODES:
                                                          REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB
                                                                    IN THE CODES APPENDIX

                                                        SOURCE:
                                                        CWF

                                                        Claims processed prior to 8/18/00 will contain
                                                        spaces in this field.

                                                        DB2 ALIAS: REV_APC_HIPPS_CD
                                                        SAS ALIAS: APCHIPPS
                                                        STANDARD ALIAS: REV_CNTR_APC_HIPPS_CD
                                                        SYSTEM ALIAS: LTAPC
                                                        TITLE ALIAS: APC_HIPPS

                                                        CODES:
                                                          REFER TO: REV_CNTR_APC_TB
                                                                    IN THE CODES APPENDIX
```

1   BENE_IDENT_TB   Beneficiary Identification Code (BIC) Table
      -------------   ---

Social Security Administration:

A = Primary claimant
B = Aged wife, age 62 or over (1st
     claimant)
B1 = Aged husband, age 62 or over (1st
     claimant)
B2 = Young wife, with a child in her care
     (1st claimant)
B3 = Aged wife (2nd claimant)
B4 = Aged husband (2nd claimant)
B5 = Young wife (2nd claimant)
B6 = Divorced wife, age 62 or over (1st
     claimant)
B7 = Young wife (3rd claimant)
B8 = Aged wife (3rd claimant)
B9 = Divorced wife (2nd claimant)
BA = Aged wife (4th claimant)
BD = Aged wife (5th claimant)
BG = Aged husband (3rd claimant)
BH = Aged husband (4th claimant)
BJ = Aged husband (5th claimant)
BK = Young wife (4th claimant)
BL = Young wife (5th claimant)
BN = Divorced wife (3rd claimant)
BP = Divorced wife (4th claimant)
BQ = Divorced wife (5th claimant)
BR = Divorced husband (1st claimant)
BT = Divorced husband (2nd claimant)
BW = Young husband (2nd claimant)
BY = Young husband (1st claimant)
C1-C9,CA-CZ = Child (includes minor, student
             or disabled child)
D = Aged widow, 60 or over (1st claimant)
D1 = Aged widower, age 60 or over (1st
     claimant)
D2 = Aged widow (2nd claimant)
D3 = Aged widower (2nd claimant)
D4 = Widow (remarried after attainment of
     age 60) (1st claimant)
D5 = Widower (remarried after attainment of
     age 60) (1st claimant)
D6 = Surviving divorced wife, age 60 or over
     (1st claimant)
D7 = Surviving divorced wife (2nd claimant)
D8 = Aged widow (3rd claimant)
D9 = Remarried widow (2nd claimant)
DA = Remarried widow (3rd claimant)
DC = Surviving divorced husband (1st claimant)
DD = Aged widow (4th claimant)

```
                                  DG = Aged widow (5th claimant)
                                  DH = Aged widower (3rd claimant)
                                  DJ = Aged widower (4th claimant)
                                  DK = Aged widower (5th claimant)
                                  DL = Remarried widow (4th claimant)
                                  DM = Surviving divorced husband (2nd
                                       claimant)
                                  DN = Remarried widow (5th claimant)
1        BENE_IDENT_TB                    Beneficiary Identification Code (BIC) Table
         -------------                    -----------------------------------------

                                  DP = Remarried widower (2nd claimant)
                                  DQ = Remarried widower (3rd claimant)
                                  DR = Remarried widower (4th claimant)
                                  DS = Surviving divorced husband (3rd
                                       claimant)
                                  DT = Remarried widower (5th claimant)
                                  DV = Surviving divorced wife (3rd claimant)
                                  DW = Surviving divorced wife (4th claimant)
                                  DX = Surviving divorced husband (4th
                                       claimant)
                                  DY = Surviving divorced wife (5th claimant)
                                  DZ = Surviving divorced husband (5th
                                       claimant)
                                  E  = Mother (widow) (1st claimant)
                                  E1 = Surviving divorced mother (1st
                                       claimant)
                                  E2 = Mother (widow) (2nd claimant)
                                  E3 = Surviving divorced mother (2nd
                                       claimant)
                                  E4 = Father (widower) (1st claimant)
                                  E5 = Surviving divorced father (widower)
                                       (1st claimant)
                                  E6 = Father (widower) (2nd claimant)
                                  E7 = Mother (widow) (3rd claimant)
                                  E8 = Mother (widow) (4th claimant)
                                  E9 = Surviving divorced father (widower)
                                       (2nd claimant)
                                  EA = Mother (widow) (5th claimant)
                                  EB = Surviving divorced mother (3rd
                                       claimant)
                                  EC = Surviving divorced mother (4th
                                       claimant)
                                  ED = Surviving divorced mother (5th
                                       claimant
                                  EF = Father (widower) (3rd claimant)
                                  EG = Father (widower) (4th claimant)
                                  EH = Father (widower) (5th claimant)
                                  EJ = Surviving divorced father (3rd
                                       claimant)
                                  EK = Surviving divorced father (4th
                                       claimant)
                                  EM = Surviving divorced father (5th
                                       claimant)
                                  F1 = Father
                                  F2 = Mother
                                  F3 = Stepfather
                                  F4 = Stepmother
```

```
                     F5 = Adopting father
                     F6 = Adopting mother
                     F7 = Second alleged father
                     F8 = Second alleged mother
                     J1 = Primary prouty entitled to HIB
                          (less than 3 Q.C.) (general fund)
                     J2 = Primary prouty entitled to HIB
                          (over 2 Q.C.) (RSI trust fund)
                     J3 = Primary prouty not entitled to HIB
                          (less than 3 Q.C.) (general fund)
                     J4 = Primary prouty not entitled to HIB
 1        BENE_IDENT_TB              Beneficiary Identification Code (BIC) Table
          -------------              ------------------------------------------

                          (over 2 Q.C.) (RSI trust fund)
                     K1 = Prouty wife entitled to HIB (less than
                          3 Q.C.) (general fund) (1st claimant)
                     K2 = Prouty wife entitled to HIB (over 2
                          Q.C.) (RSI trust fund) (1st claimant)
                     K3 = Prouty wife not entitled to HIB (less
                          than 3 Q.C.) (general fund) (1st
                          claimant)
                     K4 = Prouty wife not entitled to HIB (over
                          2 Q.C.) (RSI trust fund) (1st
                          claimant)
                     K5 = Prouty wife entitled to HIB (less than
                          3 Q.C.) (general fund) (2nd claimant)
                     K6 = Prouty wife entitled to HIB (over 2
                          Q.C.) (RSI trust fund) (2nd claimant)
                     K7 = Prouty wife not entitled to HIB (less
                          than 3 Q.C.) (general fund) (2nd
                          claimant)
                     K8 = Prouty wife not entitled to HIB (over
                          2 Q.C.) (RSI trust fund) (2nd
                          claimant)
                     K9 = Prouty wife entitled to HIB (less than
                          3 Q.C.) (general fund) (3rd claimant)
                     KA = Prouty wife entitled to HIB (over 2
                          Q.C.) (RSI trust fund) (3rd claimant)
                     KB = Prouty wife not entitled to HIB (less
                          than 3 Q.C.) (general fund) (3rd
                          claimant)
                     KC = Prouty wife not entitled to HIB (over
                          2 Q.C.) (RSI trust fund) (3rd
                          claimant)
                     KD = Prouty wife entitled to HIB (less than
                          3 Q.C.) (general fund) (4th claimant)
                     KE = Prouty wife entitled to HIB (over 2 Q.C
                          (4th claimant)
                     KF = Prouty wife not entitled to HIB (less
                          than 3 Q.C.)(4th claimant)
                     KG = Prouty wife not entitled to HIB (over
                          2 Q.C.)(4th claimant)
                     KH = Prouty wife entitled to HIB (less than
                          3 Q.C.)(5th claimant)
                     KJ = Prouty wife entitled to HIB (over 2
                          Q.C.) (5th claimant)
                     KL = Prouty wife not entitled to HIB (less
```

```
                                 than 3 Q.C.)(5th claimant)
                         KM = Prouty wife not entitled to HIB (over
                                 2 Q.C.) (5th claimant)
                         M  = Uninsured-not qualified for deemed HIB
                         M1 = Uninsured-qualified but refused HIB
                         T  = Uninsured-entitled to HIB under deemed
                                 or renal provisions
                         TA = MQGE (primary claimant)
                         TB = MQGE aged spouse (first claimant)
                         TC = MQGE disabled adult child (first claimant)
                         TD = MQGE aged widow(er) (first claimant)
                         TE = MQGE young widow(er) (first claimant)
                         TF = MQGE parent (male)
                         TG = MQGE aged spouse (second claimant)
1        BENE_IDENT_TB            Beneficiary Identification Code (BIC) Table
         -------------            -------------------------------------------

                         TH = MQGE aged spouse (third claimant)
                         TJ = MQGE aged spouse (fourth claimant)
                         TK = MQGE aged spouse (fifth claimant)
                         TL = MQGE aged widow(er) (second claimant)
                         TM = MQGE aged widow(er) (third claimant)
                         TN = MQGE aged widow(er) (fourth claimant)
                         TP = MQGE aged widow(er) (fifth claimant)
                         TQ = MQGE parent (female)
                         TR = MQGE young widow(er) (second claimant)
                         TS = MQGE young widow(er) (third claimant)
                         TT = MQGE young widow(er) (fourth claimant)
                         TU = MQGE young widow(er) (fifth claimant)
                         TV = MQGE disabled widow(er) fifth claimant
                         TW = MQGE disabled widow(er) first claimant
                         TX = MQGE disabled widow(er) second claimant
                         TY = MQGE disabled widow(er) third claimant
                         TZ = MQGE disabled widow(er) fourth claimant
                         T2-T9 = Disabled child (second to ninth
                                 claimant)
                         W  = Disabled widow, age 50 or over (1st
                                 claimant)
                         W1 = Disabled widower, age 50 or over (1st
                                 claimant)
                         W2 = Disabled widow (2nd claimant)
                         W3 = Disabled widower (2nd claimant)
                         W4 = Disabled widow (3rd claimant)
                         W5 = Disabled widower (3rd claimant)
                         W6 = Disabled surviving divorced wife (1st
                                 claimant)
                         W7 = Disabled surviving divorced wife (2nd
                                 claimant)
                         W8 = Disabled surviving divorced wife (3rd
                                 claimant)
                         W9 = Disabled widow (4th claimant)
                         WB = Disabled widower (4th claimant)
                         WC = Disabled surviving divorced wife (4th
                                 claimant)
                         WF = Disabled widow (5th claimant)
                         WG = Disabled widower (5th claimant)
                         WJ = Disabled surviving divorced wife (5th
                                 claimant)
```

```
           WR = Disabled surviving divorced husband
                (1st claimant)
           WT = Disabled surviving divorced husband
                (2nd claimant)

        Railroad Retirement Board:

           NOTE:
           Employee:  a Medicare beneficiary who is
                      still working or a worker who
                      died before retirement
           Annuitant: a person who retired under the
                      railroad retirement act on or
                      after 03/01/37
           Pensioner: a person who retired prior to
                      03/01/37 and was included in the
                      railroad retirement act
1      BENE_IDENT_TB                Beneficiary Identification Code (BIC) Table
       -------------                -----------------------------------------


           10 = Retirement - employee or annuitant
           80 = RR pensioner (age or disability)
           14 = Spouse of RR employee or annuitant
                (husband or wife)
           84 = Spouse of RR pensioner
           43 = Child of RR employee
           13 = Child of RR annuitant
           17 = Disabled adult child of RR annuitant
           46 = Widow/widower of RR employee
           16 = Widow/widower of RR annuitant
           86 = Widow/widower of RR pensioner
           43 = Widow of employee with a child in her care
           13 = Widow of annuitant with a child in her care
           83 = Widow of pensioner with a child in her care
           45 = Parent of employee
           15 = Parent of annuitant
           85 = Parent of pensioner
           11 = Survivor joint annuitant
                (reduced benefits taken to insure benefits
                for surviving spouse)


1      BENE_PRMRY_PYR_TB                    Beneficiary Primary Payer Table
       -----------------                    -------------------------------


           A = Working aged bene/spouse with employer
               group health plan (EGHP)
           B = End stage renal disease (ESRD) beneficiary
               in the 18 month coordination period with
               an employer group health plan
           C = Conditional payment by Medicare; future
               reimbursement expected
           D = Automobile no-fault (eff. 4/97; Prior
               to 3/94, also included any liability
               insurance)
           E = Workers' compensation
           F = Public Health Service or other federal
```

```
                    agency (other than Dept. of Veterans
                    Affairs)
            G = Working disabled bene (under age 65
                    with LGHP)
            H = Black Lung
            I = Dept. of Veterans Affairs
            J = Any liability insurance
                    (eff. 3/94 - 3/97)
            L = Any liability insurance (eff. 4/97)
                    (eff. 12/90 for carrier claims and 10/93
                    for FI claims; obsoleted for all claim
                    types 7/1/96)

            M = Override code:  EGHP services involved
                    (eff. 12/90 for carrier claims and 10/93
                    for FI claims; obsoleted for all claim
                    types 7/1/96)

            N = Override code:  non-EGHP services involved
                    (eff. 12/90 for carrier claims and 10/93
                    for FI claims; obsoleted for all claim
                    types 7/1/96)

            BLANK = Medicare is primary payer (not sure
                    of effective date: in use 1/91, if
                    not earlier)

            T = MSP cost avoided - IEQ contractor
                    (eff. 7/96 carrier claims only)
            U = MSP cost avoided - HMO rate cell adjust-
                    ment contractor (eff. 7/96 carrier claims
                    only)
            V = MSP cost avoided - litigation settlement
                    contractor (eff. 7/96 carrier claims
                    only)

            X = MSP cost avoided override code (eff.
                    12/90 for carrier claims and 10/93 for
                    FI claims; obsoleted for all claim types
                    7/1/96)

                            ***Prior to 12/90***

            Y = Other secondary payer investigation
                    shows Medicare as primary payer
```

1	BENE_PRMRY_PYR_TB	Beneficiary Primary Payer Table
	-----------------	------------------------------

```
            Z = Medicare is primary payer

            NOTE:  Values C, M, N, Y, Z and BLANK
                    indicate Medicare is primary payer.
                    (values Z and Y were used prior to
                    12/90.  BLANK was suppose to be
                    effective after 12/90, but may have
                    been used prior to that date.)
```

1	BETOS_TB	BETOS Table

```
--------                                  -----------

                M1A = Office visits - new
                M1B = Office visits - established
                M2A = Hospital visit - initial
                M2B = Hospital visit - subsequent
                M2C = Hospital visit - critical care
                M3  = Emergency room visit
                M4A = Home visit
                M4B = Nursing home visit
                M5A = Specialist - pathology
                M5B = Specialist - psychiatry
                M5C = Specialist - opthamology
                M5D = Specialist - other
                M6  = Consultations
                P0  = Anesthesia
                P1A = Major procedure - breast
                P1B = Major procedure - colectomy
                P1C = Major procedure - cholecystectomy
                P1D = Major procedure - turp
                P1E = Major procedure - hysterctomy
                P1F = Major procedure - explor/decompr/excisdisc
                P1G = Major procedure - Other
                P2A = Major procedure, cardiovascular-CABG
                P2B = Major procedure, cardiovascular-Aneurysm repair
                P2C = Major Procedure, cardiovascular-Thromboendarterectomy
                P2D = Major procedure, cardiovascualr-Coronary angioplasty (PTCA)
                P2E = Major procedure, cardiovascular-Pacemaker insertion
                P2F = Major procedure, cardiovascular-Other
                P3A = Major procedure, orthopedic - Hip fracture repair
                P3B = Major procedure, orthopedic - Hip replacement
                P3C = Major procedure, orthopedic - Knee replacement
                P3D = Major procedure, orthopedic - other
                P4A = Eye procedure - corneal transplant
                P4B = Eye procedure - cataract removal/lens insertion
                P4C = Eye procedure - retinal detachment
                P4D = Eye procedure - treatment
                P4E = Eye procedure - other
                P5A = Ambulatory procedures - skin
                P5B = Ambulatory procedures - musculoskeletal
                P5C = Ambulatory procedures - inguinal hernia repair
                P5D = Ambulatory procedures - lithotripsy
                P5E = Ambulatory procedures - other
                P6A = Minor procedures - skin
                P6B = Minor procedures - musculoskeletal
                P6C = Minor procedures - other (Medicare fee schedule)
                P6D = Minor procedures - other (non-Medicare fee schedule)
                P7A = Oncology - radiation therapy
                P7B = Oncology - other
                P8A = Endoscopy - arthroscopy
                P8B = Endoscopy - upper gastrointestinal
                P8C = Endoscopy - sigmoidoscopy
                P8D = Endoscopy - colonoscopy
                P8E = Endoscopy - cystoscopy
                P8F = Endoscopy - bronchoscopy
                P8G = Endoscopy - laparoscopic cholecystectomy
                P8H = Endoscopy - laryngoscopy
```

```
                              P8I = Endoscopy - other
                              P9A = Dialysis services
1           BETOS_TB                                  BETOS Table
            --------                                  -----------


                              I1A = Standard imaging - chest
                              I1B = Standard imaging - musculoskeletal
                              I1C = Standard imaging - breast
                              I1D = Standard imaging - contrast gastrointestinal
                              I1E = Standard imaging - nuclear medicine
                              I1F = Standard imaging - other
                              I2A = Advanced imaging - CAT: head
                              I2B = Advanced imaging - CAT: other
                              I2C = Advanced imaging - MRI: brain
                              I2D = Advanced imaging - MRI: other
                              I3A = Echography - eye
                              I3B = Echography - abdomen/pelvis
                              I3C = Echography - heart
                              I3D = Echography - carotid arteries
                              I3E = Echography - prostate, transrectal
                              I3F = Echography - other
                              I4A = Imaging/procedure - heart including cardiac
                                                   catheter
                              I4B = Imaging/procedure - other
                              T1A = Lab tests - routine venipuncture (non Medicare
                                               fee schedule)
                              T1B = Lab tests - automated general profiles
                              T1C = Lab tests - urinalysis
                              T1D = Lab tests - blood counts
                              T1E = Lab tests - glucose
                              T1F = Lab tests - bacterial cultures
                              T1G = Lab tests - other (Medicare fee schedule)
                              T1H = Lab tests - other (non-Medicare fee schedule)
                              T2A = Other tests - electrocardiograms
                              T2B = Other tests - cardiovascular stress tests
                              T2C = Other tests - EKG monitoring
                              T2D = Other tests - other
                              D1A = Medical/surgical supplies
                              D1B = Hospital beds
                              D1C = Oxygen and supplies
                              D1D = Wheelchairs
                              D1E = Other DME
                              D1F = Orthotic devices
                              O1A = Ambulance
                              O1B = Chiropractic
                              O1C = Enteral and parenteral
                              O1D = Chemotherapy
                              O1E = Other drugs
                              O1F = Vision, hearing and speech services
                              O1G = Influenza immunization
                              Y1  = Other - Medicare fee schedule
                              Y2  = Other - non-Medicare fee schedule
                              Z1  = Local codes
                              Z2  = Undefined codes


1     CARR_CLM_PMT_DNL_TB                    Carrier Claim Payment Denial Table
      -------------------                    ----------------------------------
```

```
0 = Denied
1 = Physician/supplier
2 = Beneficiary
3 = Both physician/supplier and beneficiary
4 = Hospital (hospital based physicians)
5 = Both hospital and beneficiary
6 = Group practice prepayment plan
7 = Other entries (e.g. Employer, union)
8 = Federally funded
9 = PA service
A = Beneficiary under limitation of
    liability
B = Physician/supplier under limitation of
    liability
D = Denied due to demonstration involvement
    (eff. 5/97)
E = MSP cost avoided IRS/SSA/HCFA Data
    Match (eff. 7/3/00)
F = MSP cost avoided HMO Rate Cell
    (eff. 7/3/00)
G = MSP cost avoided Litigation Settlement
    (eff. 7/3/00)
H = MSP cost avoided Employer Voluntary
    Reporting (eff. 7/3/00)
J = MSP cost avoided Insurer Voluntary
    Reporting (eff. 7/3/00)
K = MSP cost avoided Initial Enrollment
    Questionnaire (eff. 7/3/00)
P = Physician ownership denial (eff 3/92)
Q = MSP cost avoided - (Contractor #88888)
    voluntary agreement (eff. 1/98)
T = MSP cost avoided - IEQ contractor
    (eff. 7/96) (obsolete 6/30/00)
U = MSP cost avoided - HMO rate cell
    adjustment (eff. 7/96) (obsolete 6/30/00)
V = MSP cost avoided - litigation
    settlement (eff. 7/96) (obsolete 6/30/00)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data
    match project (obsolete 6/30/00)
```

1	CARR_LINE_PRVDR_TYPE_TB	Carrier Line Provider Type Table
	-----------------------	--------------------------------

```
For Physician/Supplier (RIC O) Claims:

0 = Clinics, groups, associations,
    partnerships, or other entities
1 = Physicians or suppliers reporting as
    solo practitioners
2 = Suppliers (other than sole proprietorship)
3 = Institutional provider
4 = Independent laboratories
5 = Clinics (multiple specialties)
6 = Groups (single specialty)
7 = Other entities
```

```
                    For DMERC (RIC M) Claims - PRIOR TO VERSION H:


                    0 = Clinics, groups, associations,
                        partnerships, or other entities
                        for whom the carrier's own ID number
                        has been assigned.
                    1 = Physicians or suppliers billing as
                        solo practitioners for whom SSN's are
                        shown in the physician ID code field.
                    2 = Physicians or suppliers billing as
                        solo practitioners for whom the carrier's
                        own physician ID code is shown.
                    3 = Suppliers (other than sole proprietorship)
                        for whom EI numbers are used in coding the
                        ID field.
                    4 = Suppliers (other than sole proprietorship)
                        for whom the carrier's own code has been
                        shown.
                    5 = Institutional providers and
                        independent laboratories for whom EI
                        numbers are used in coding the ID field.
                    6 = Institutional providers and
                        independent laboratories for whom the
                        carrier's own ID number is shown.
                    7 = Clinics, groups, associations, or
                        partnerships for whom EI numbers
                        are used in coding the ID field.
                    8 = Other entities for whom EI numbers
                        are used in coding the ID field or
                        proprietorship for whom EI numbers are
                        used in coding the ID field.


1CARR_LINE_RDCD_PHYSN_ASTNT_TB          Carrier Line Part B Reduced Physician Assistant Table
 ---------------------------            ----------------------------------------------------


                    BLANK = Adjustment situation (where
                            CLM_DISP_CD equal 3)
                    0 = N/A
                    1 = 65%
                        A) Physician assistants assisting in
                           surgery
                        B) Nurse midwives
                    2 = 75%
                        A) Physician assistants performing
                           services in a hospital (other than
                           assisting surgery)
                        B) Nurse practitioners and clinical
                           nurse specialists performing
                           services in rural areas
                        C) Clinical social worker services
                    3 = 85%
                        A) Physician assistant services for
                           other than assisting surgery
                        B) Nurse practitioners services


1       CARR_NUM_TB                              Carrier Number Table
```

```
----------                              --------------------

                00510 = Alabama BS (eff. 1983)
                00511 = Georgia - Alabama BS (eff. 1998)
                00512 = Mississippi - Alabama BS (eff. 2000)
                00520 = Arkansas BS (eff. 1983)
                00521 = New Mexico - Arkansas BS (eff. 1998)
                00522 = Oklahoma - Arkansas BS (eff. 1998)
                00523 = Missouri - Arkansas BS (eff. 1999)
                00528 = Louisianna - Arkansas BS (eff. 1984)
                00542 = California BS (eff. 1983; term. 1996)
                00550 = Colorado BS (eff. 1983; term. 1994)
                00570 = Delaware - Pennsylvania BS (eff. 1983;
                        term. 1997)
                00580 = District of Columbia - Pennsylvania BS
                        (eff. 1983; term. 1997)
                00590 = Florida BS (eff. 1983)
                00591 = Connecticut - Florida BS (eff. 2000)
                00621 = Illinois BS - HCSC (eff. 1983; term. 1998)
                00623 = Michigan - Illinois Blue Shield (eff. 1995)
                        (term. 1998)
                00630 = Indiana - Administar (eff. 1983)
                00635 = DMERC-B (Administar Federal, Inc.)
                        (eff. 1993)
                00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 1998)
                00645 = Nebraska - Iowa BS (eff. 1985; term. 1987)
                00650 = Kansas BS (eff. 1983)
                00655 = Nebraska - Kansas BS (eff. 1988)
                00660 = Kentucky - Administar (eff. 1983)
                00690 = Maryland BS (eff. 1983; term. 1994)
                00700 = Massachusetts BS (eff. 1983; term. 1997)
                00710 = Michigan BS (eff. 1983; term. 1994)
                00720 = Minnesota BS (eff. 1983; term. 1995)
                00740 = Missouri - BS Kansas City (eff. 1983)
                00751 = Montana BS (eff. 1983)
                00770 = New Hampshire/Vermont Physician Services
                        (eff. 1983; term. 1984)
                00780 = New Hampshire/Vermont - Massachusetts BS
                        (eff. 1985; term. 1997)
                00801 = New York - Western BS (eff. 1983)
                00803 = New York - Empire BS (eff. 1983)
                00805 = New Jersey - Empire BS (eff. 3/99)
                00811 = DMERC (A) - Western New York BS (eff. 2000)
                00820 = North Dakota - North Dakota BS (eff. 1983)
                00824 = Colorado - North Dakota BS (eff. 1995)
                00825 = Wyoming - North Dakota BS (eff. 1990)
                00826 = Iowa - North Dakota BS (eff. 1999)
                00831 = Alaska - North Dakota BS (eff. 1998)
                00832 = Arizona -  North Dakota BS (eff. 1998)
                00833 = Hawaii - North Dakota BS (eff. 1998)
                00834 = Nevada - North Dakota BS (eff. 1998)
                00835 = Oregon - North Dakota BS (eff. 1998)
                00836 = Washington - North Dakota BS (eff. 1998)
                00860 = New Jersey - Pennsylvania BS (eff. 1988;
                        term. 1999)
                00865 = Pennsylvania BS (eff. 1983)
                00870 = Rhode Island BS (eff. 1983)
```

```
                              00880 = South Carolina BS (eff. 1983)
                              00882 = RRB - South Carolina PGBA (eff. 2000)
1       CARR_NUM_TB                           Carrier Number Table
        -----------                           --------------------

                              00885 = DMERC C - Palmetto (eff. 1993)
                              00900 = Texas BS (eff. 1983)
                              00901 = Maryland - Texas BS (eff. 1995)
                              00902 = Delaware - Texas BS (eff. 1998)
                              00903 = District of Columbia - Texas BS (eff. 1998)
                              00904 = Virginia - Texas BS (eff. 2000)
                              00910 = Utah  BS (eff. 1983)
                              00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)
                              00952 = Illinois - Wisconsin Phy Svc (eff. 1999)
                              00953 = Michigan - Wisconsin Phy Svc (eff. 1999)
                              00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)
                              00973 = Triple-S, Inc. - Puerto Rico (eff. 1983)
                              00974 = Triple-S, Inc. - Virgin Islands
                              01020 = Alaska - AETNA (eff. 1983; term. 1997)
                              01030 = Arizona - AETNA (eff. 1983; term. 1997)
                              01040 = Georgia - AETNA (eff. 1988; term. 1997)
                              01120 = Hawaii - AETNA (eff. 1983; term. 1997)
                              01290 = Nevada - AETNA (eff. 1983; term. 1997)
                              01360 = New Mexico - AETNA (eff. 1986; term. 1997)
                              01370 = Oklahoma - AETNA (eff. 1983; term. 1997)
                              01380 = Oregon - AETNA (eff. 1983; term. 1997
                              01390 = Washington - AETNA (eff. 1994; term. 1997)
                              02050 = California - TOLIC (eff. 1983)
                                      (term. 2000)
                              03070 = Connecticut General Life Insurance Co.
                                      (eff. 1983; term. 1985)
                              05130 = Idaho - Connecticut General (eff. 1983)
                              05320 = New Mexico - Equitable Insurance
                                      (eff. 1983; term. 1985)
                              05440 = Tennessee - Connecticut General (eff. 1983)
                              05530 = Wyoming - Equitable Insurance (eff. 1983)
                                      (term. 1989)
                              05535 = North Carolina - Connecticut General
                                      (eff. 1988)
                              05655 = DMERC-D - Connecticut General (eff. 1993)
                              10071 = Railroad Board Travelers (eff. 1983)
                                      (term. 2000)
                              10230 = Connecticut - Metra Health (eff. 1986)
                                      (term. 2000)
                              10240 = Minnesota - Metra Health (eff. 1983)
                                      (term. 2000)
                              10250 = Mississippi - Metra Health (eff. 1983)
                                      (term. 2000)
                              10490 = Virginia - Metra Health (eff. 1983)
                                      (term. 2000)
                              10555 = Travelers Insurance Co. (eff. 1993)
                                      (term. 2000)
                              11260 = Missouri - General American Life
                                      (eff. 1983; term. 1998)
                              14330 = New York - GHI (eff. 1983)
                              16360 = Ohio - Nationwide Insurance Co.
                              16510 = West Virginia - Nationwide Insurance Co.
                              21200 = Maine - BS of Massachusetts
```

```
                          31140 = California - National Heritage Ins.
                          31142 = Maine - National Heritage Ins.
                          31143 = Massachusetts - National Heritage Ins.
                          31144 = New Hampshire - National Heritage Ins.
                          31145 = Vermont - National Heritage Ins.
1        CARR_NUM_TB                          Carrier Number Table
         -----------                          --------------------

                          31146 = So. California - NHIC (eff. 2000)

1        CLM_BILL_TYPE_TB                     Claim Bill Type Table
         ----------------                     ---------------------


                          11 = Hospital-inpatient (including Part A)
                          12 = Hospital-inpatient or home health visits (Part B only)
                          13 = Hospital-outpatient (HHA-A also) (under OPPS 13X
                               must be used for ASC claims submitted for OPPS
                               payment -- eff. 7/00)
                          14 = Hospital-other (Part B)
                          15 = Hospital-intermediate care - level I
                          16 = Hospital-intermediate care - level II
                          17 = Hospital-intermediate care - level III
                          18 = Hospital-swing beds
                          19 = Hospital-reserved for national assignment
                          21 = SNF-inpatient (including Part A)
                          22 = SNF-inpatient or home health visits (Part B only)
                          23 = SNF-outpatient (HHA-A also)
                          24 = SNF-other (Part B)
                          25 = SNF-intermediate care - level I
                          26 = SNF-intermediate care - level II
                          27 = SNF-intermediate care - level III
                          28 = SNF-swing beds
                          29 = SNF-reserved for national assignment
                          31 = HHA-inpatient (including Part A)
                          32 = HHA-inpatient or home health visits (Part B only)
                          33 = HHA-outpatient (HHA-A also)
                          34 = HHA-other (Part B)
                          35 = HHA-intermediate care - level I
                          36 = HHA-intermediate care - level II
                          37 = HHA-intermediate care - level III
                          38 = HHA-swing beds
                          39 = HHA-reserved for national assignment
                          41 = Religious Nonmedical Health Care Institution (RNHCI)
                               hospital-inpatient (including Part A) (all references
                               to Christian Science (CS) is obsolete eff. 8/00 and
                               replaced with RNHCI)
                          42 = RNHCI hospital-inpatient or home health visits (Part B only)
                          43 = RNHCI hospital-outpatient (HHA-A also)
                          44 = RNHCI hospital-other (Part B)
                          45 = RNHCI hospital-intermediate care - level I
                          46 = RNHCI hospital-intermediate care - level II
                          47 = RNHCI hospital-intermediate care - level III
                          48 = RNHCI hospital-swing beds
                          49 = RNHCI hospital-reserved for national assignment
                          51 = CS extended care-inpatient (including Part A) OBSOLETE
                               eff. 7/00 - implementation of Religious Nonmedical
                               Health Care Institutions (RNHCI)
```

```
                                 52 = RNHCI extended care-inpatient or home health visits
                                      (Part B only) (eff. 7/00); prior to 7/00 Christian Science (CS)
                                 53 = RNHCI extended care-outpatient (HHA-A also) (eff. 7/00);
                                      prior to 7/00 referenced CS
                                 54 = RNHCI extended care-other (Part B)(eff. 7/00); prior
                                      to 7/00 referenced CS
                                 55 = RNHCI extended care-intermediate care - level I (eff. 7/00)
                                      prior to 7/00 referenced CS
                                 56 = RNHCI extended care-intermediate care - level II (eff. 7/00)
                                      prior to 7/00 referenced CS
                                 57 = RNHCI extended care-intermediate care - level III (eff. 7/00)
                                      prior to 7/00 referenced CS
                                 58 = RNHCI extended care-swing beds (eff. 7/00)
1       CLM_BILL_TYPE_TB                       Claim Bill Type Table
        ----------------                       ---------------------

                                      prior to 7/00 referenced CS
                                 59 = RNHCI extended care-reserved for national assignment
                                      (eff. 7/00); prior to 7/00 referenced CS
                                 61 = Intermediate care-inpatient (including Part A)
                                 62 = Intermediate care-inpatient or home health visits (Part B only)
                                 63 = Intermediate care-outpatient (HHA-A also)
                                 64 = Intermediate care-other (Part B)
                                 65 = Intermediate care-intermediate care - level I
                                 66 = Intermediate care-intermediate care - level II
                                 67 = Intermediate care-intermediate care - level III
                                 68 = Intermediate care-swing beds
                                 69 = Intermediate care-reserved for national assignment
                                 71 = Clinic-rural health
                                 72 = Clinic-hospital based or independent renal dialysis facility
                                 73 = Clinic-independent provider based FQHC (eff 10/91)
                                 74 = Clinic-ORF only (eff 4/97);
                                      ORF and CMHC (10/91 - 3/97)
                                 75 = Clinic-CORF
                                 76 = Clinic-CMHC (eff 4/97)
                                 77 = Clinic-reserved for national assignment
                                 78 = Clinic-reserved for national assignment
                                 79 = Clinic-other
                                 81 = Special facility or ASC surgery-hospice (non-hospital based)
                                 82 = Special facility or ASC surgery-hospice (hospital based)
                                 83 = Special facility or ASC surgery-ambulatory surgical center
                                      (Discontinued for Hospitals Subject to Outpatient PPS;
                                       hospitals must use 13X for ASC claims submitted for OPPS
                                       payment -- eff. 7/00)
                                 84 = Special facility or ASC surgery-freestanding birthing center
                                 85 = Special facility or ASC surgery-rural primary care hospital (eff
                                 86 = Special facility or ASC surgery-reserved for national use
                                 87 = Special facility or ASC surgery-reserved for national use
                                 88 = Special facility or ASC surgery-reserved for national use
                                 89 = Special facility or ASC surgery-other
                                 91 = Reserved-inpatient (including Part A)
                                 92 = Reserved-inpatient or home health visits (Part B only)
                                 93 = Reserved-outpatient (HHA-A also)
                                 94 = Reserved-other (Part B)
                                 95 = Reserved-intermediate care - level I
                                 96 = Reserved-intermediate care - level II
                                 97 = Reserved-intermediate care - level III
                                 98 = Reserved-swing beds
```

```
                           99 = Reserved-reserved for national assignment

1         CLM_DISP_TB                          Claim Disposition Table
          -----------                          -----------------------


                           01 = Debit accepted
                           02 = Debit accepted (automatic adjustment)
                                applicable through 4/4/93
                           03 = Cancel accepted
                           61 = *Conversion code: debit accepted
                           62 = *Conversion code: debit accepted
                                (automatic adjustment)
                           63 = *Conversion code: cancel accepted

                             *Used only during conversion period:
                                   1/1/91 - 2/21/91

1         CLM_FAC_TYPE_TB                      Claim Facility Type Table
          ---------------                      -------------------------


                           1 = Hospital
                           2 = Skilled nursing facility (SNF)
                           3 = Home health agency (HHA)
                           4 = Religious Nonmedical (Hospital)
                               (eff. 8/1/00); prior to 8/00 referenced Christian
                               Science (CS)
                           5 = Religious Nonmedical (Extended Care)
                               (eff. 8/1/00); prior to 8/00 referenced CS
                           6 = Intermediate care
                           7 = Clinic or hospital-based renal dialysis facility
                           8 = Special facility or ASC surgery
                           9 = Reserved

1         CLM_FREQ_TB                          Claim Frequency Table
          -----------                          ---------------------


                           0 = Non-payment/zero claims
                           1 = Admit thru discharge claim
                           2 = Interim - first claim
                           3 = Interim - continuing claim
                           4 = Interim - last claim
                           5 = Late charge(s) only claim
                           6 = Adjustment of prior claim
                           7 = Replacement of prior claim;
                               eff 10/93, provider debit
                           8 = Void/cancel prior claim.
                               eff 10/93, provider cancel
                           9 = Final claim -- used in an HH PPS
                               episode to indicate the claim
                               should be processed like debit/
                               credit adjustment to RAP (initial
                               claim) (eff. 10/00)
                           A = Admission notice - used when hospice
                               is submitting the HCFA-1450 as an
                               admission notice - hospice NOE only
```

```
             B = Hospice termination/revocation notice
                 - hospice NOE only  (eff 9/93)
             C = Hospice change of provider notice
                 - hospice NOE only (eff 9/93)
             D = Hospice election void/cancel
                 - hospice NOE only  (eff 9/93)
             E = Hospice change of ownership
                 - hospice NOE only  (eff 1/97)
             F = Beneficiary initiated adjustment
                 (eff 10/93)
             G = CWF generated adjustment (eff 10/93)
             H = HCFA generated adjustment (eff 10/93)
             I = Misc adjustment claim (other than PRO
                 or provider) - used to identify a
                 debit adjustment initiated by HCFA or
                 an intermediary - eff 10/93, used to
                 identify intermediary initiated
                 adjustment only
             J = Other adjustment request (eff 10/93)
             K = OIG initiated adjustment (eff 10/93)
             M = MSP adjustment (eff 10/93)
             P = Adjustment required by peer review
                 organization (PRO)
             X = Special adjustment processing - used
                 for QA editing (eff 8/92)
             Z = Hospital Encounter Data alternate sub-
                 mission (TOB '11Z') used for MCO enrollee
                 hospital discharges 7/1/97-12/31/98; not
                 stored in NCH.  Exception:  Problem in
                 startup months may have resulted in this
                 abbreviated UB-92 being erroneously
                 stored in NCH.
```

1	CLM_HHA_RFRL_TB	Claim Home Health Referral Table
	---------------	-------------------------------

```
             1 = Physician referral - The patient was
                 admitted upon the recommendation of
                 a personal physician.
             2 = Clinic referral - The patient was
                 admitted upon the recommendation of
                 this facility's clinic physician.
             3 = HMO referral - The patient was admitted
                 upon the recommendation of an health
                 maintenance organization (HMO)
                 physician.
             4 = Transfer from hospital - The patient
                 was admitted as an inpatient transfer
                 from an acute care facility.
             5 = Transfer from a skilled nursing
                 facility (SNF) - The patient was
                 admitted as an inpatient transfer
                 from a SNF.
             6 = Transfer from another health care
                 facility - The patient was admitted
                 as a transfer from a health care
                 facility other than an acute care
```

```
                              facility or SNF.
                        7 = Emergency room - The patient was
                              admitted upon the recommendation of
                              this facility's emergency room
                              physician.
                        8 = Court/law enforcement - The patient was
                              admitted upon the direction of a
                              court of law or upon the request of
                              a law enforcement agency's
                              representative.
                        9 = Information not available -  The means
                              by which the patient was admitted is
                              not known.
                        A = Transfer from a Critical Access Hospital -
                              patient was admitted/referred to this
                              facility as a transfer from a Critical
                              Access Hospital.
                        B = Transfer from another HHA - Beneficiaries
                              are permitted to transfer from one HHA
                              to another unrelated HHA under HH PPS.
                              (eff. 10/00)
                        C = Readmission to same HHA - If a beneficiary
                              is discharged from an HHA and then re-
                              admitted within the original 60-day
                              episode, the original episode must be
                              closed early and a new once created.
                              NOTE: the use of this code will permit
                              the agency to send a new RAP allowing
                              all claims to  be accepted by Medicare.
                              (eff. 10/00)

   1       CLM_HIPPS_TB              Claim SNF & HHA Health Insurance      PPS Table
           ------------              ------------------------------------------------


                        ******************  SNF PPS HIPPS *************************
                        **************1st 3 positions (RUGS-III group)**************
                        AAA = Default: No assessment

                        BA1,BA2,BB1,BB2 = Behavior only problems (e.g.,
                                            physical/verbal abuse)

                        CA1,CA2,CB1,CB2 = Clinically-complex conditions
                        CC1,CC2            (e.g., chemo, dialysis)

                        IA1,IA2,IB1,IB2 = Impaired cognition (e.g., im-
                                            paired cognition (e.g., short-
                                            term memory)

                        PA1,PA2,PB1,PB2 = Reduced physical functions
                        PC1,PC2,PD1,PD2
                        PE1,PE2

                        RHA,RHB,RHC,RLA = Low/medium/high rehabilitation
                        RLB,RMA,RMB,RMC

                        RUA,RUB,RUC,RVA = Very high/ultra high rehabilita-
                        RVB,RVC            tion: highest level
```

```
SE1,SE2,SE3    = Extensive services; e.g.; IV feed
                 trach care

SSA,SSB,SSC    = Special care; e.g.; coma, burns

***********Positions 4 & 5 represent HIPPS modifier/********
*************** assessment type indicator ******************

00 = No assessment completed
01 = Medicare 5-day full assessment/not an initial
     admission assessment
02 = Medicare 30-day full assessment
03 = Medicare 60-day full assessment
04 = Medicare 90-day full assessment
05 = Medicare Readmission/Return required assessment
     (eff. 10/2000)
07 = Medicare 14-day full or comprehensive assessment/
     not an initial admission assessment
08 = Off-cycle Other Medicare Required Assessment (OMRA)
11 = Admission assessment AND Medicare 5-day (or readmission/
     return) assessment
17 = Medicare 14-day required assessment AND initial
     admission assessment (eff. 10/2000)
18 = OMRA replacing Medicare 5-day required assessment
     (eff. 10/2000)
28 = OMRA replacing Medicare 30-day required assessment
     (eff. 10/2000)
30 = Off-cycle significant change assessment (outside
     assessment window) (eff. 10/2000)
31 = Significant change assessment replaces Medicare
     5-day assessment (eff. 10/2000)
32 = Significant change assessment replaces Medicare
     30-day assessment
```

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table
	------------	---	

```
33 = Significant change assessment replaces Medicare
     6--day assessment
34 = Significant change assessment replaces Medicare
     90-day assessment
35 = Significant change assessment replaces a Medicare
     readmission/return assessment
37 = Significant change assessment replaces Medicare
     14-day assessment
38 = OMRA replacing Medicare 60-day required
     assessment
40 = Off-cycle significant correction assessment of a
     prior assessment (outside assessment window)
     (eff. 10/2000)
41 = Significant correction of prior full assessment
     replaces a Medicare 5-day assessment
42 = Significant correction of prior full assessment
     replaces a Medicare 30-day assessment
43 = Significant correction of prior full assessment
     replaces a Medicare 60-day assessment
44 = Significant correction of prior full assessment
     replaces a Medicare 90-day assessment
```

```
45 = Significant correction of a prior assessment
     replaces a readmission/return assessment
     (eff. 10/2000)
47 = Significant correction of prior full assessment
     replaces a Medicare 14-day required assessment
48 = OMRA replacing Medicare 90-day required assessment
54 = Quarterly review assessment - Medicare 90-day
     full assessment
78 = OMRA replacing a Medicare 14-day assessment
     (eff. 10/2000)


*****************************************************************
*****************************************************************


*************Claim Home Health PPS HIPPS Table****************
************************** KEY ********************************
Position 1 = 'H'
Position 2 = Clinical (A, B, C, D)
Position 3 = Functional (E, F, G, H, I)
Position 4 = Service (J, K, K, M)
Position 5 = identifies which elements of the code were
                computed or derived:
                1 = 2nd, 3rd, 4th positions computed
                2 = 2nd position derived
                3 = 3rd position derived
                4 = 4th position derived
                5 = 2nd & 3rd positions derived
                6 = 3rd & 4th positions derived
                7 = 2nd & 4th positions derived
                8 = 2nd, 3rd, 4th positions derived
*****************************************************************


**HHRG = C0F0S0/Clinical = Min, Functional = Min, Service = Min**
HAEJ1
HAEJ2
HAEJ3
```

1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance	PPS Table
	-----------	--	

```
HAEJ4
HAEJ5
HAEJ6
HAEJ7
HAEJ8
**HHRG = C0F0S1/Clinical = Min, Functional = Min, Service = Low**
HAEK1
HAEK2
HAEK3
HAEK4
HAEK5
HAEK6
HAEK7
HAEK8
**HHRG = C0F0S2/Clinical = Min, Functional = Min, Service = Mod**
HAEL1
HAEL2
HAEL3
```

```
                                        HAEL4
                                        HAEL5
                                        HAEL6
                                        HAEL7
                                        HAEL8
                                        **HHRG = C0F0S3/Clinical = Min, Functional = Min, Service = High**
                                        HAEM1
                                        HAEM2
                                        HAEM3
                                        HAEM4
                                        HAEM5
                                        HAEM6
                                        HAEM7
                                        HAEM8
                                        **HHRG = C0F1S0/Clinical = Min, Functional = Low, Service = Min**
                                        HAFJ1
                                        HAFJ2
                                        HAFJ3
                                        HAFJ4
                                        HAFJ5
                                        HAFJ6
                                        HAFJ7
                                        HAFJ8
                                        **HHRG = C0F1S1/Clinical = Min, Functional = Low, Service = Low**
                                        HAFK1
                                        HAFK2
                                        HAFK3
                                        HAFK4
                                        HAFK5
                                        HAFK6
                                        HAFK7
                                        HAFK8
                                        **HHRG = C0F1S2/Clinical = Min, Functional = Low, Service = Mod**
                                        HAFL1
                                        HAFL2
                                        HAFL3
                                        HAFL4
                                        HAFL5
                                        HAFL6
                                        HAFL7
1        CLM_HIPPS_TB                   Claim SNF & HHA Health Insurance      PPS Table
         ------------                   --------------------------------------------------

                                        HAFL8
                                        **HHRG = C0F1S3/Clinical = Min, Functional = Low, Service = High**
                                        HAFM1
                                        HAFM2
                                        HAFM3
                                        HAFM4
                                        HAFM5
                                        HAFM6
                                        HAFM7
                                        HAFM8
                                        **HHRG = C0F2S0/Clinical = Min, Functional = Mod, Service = Min**
                                        HAGJ1
                                        HAGJ2
                                        HAGJ3
                                        HAGJ4
```

```
                                        HAGJ5
                                        HAGJ6
                                        HAGJ7
                                        HAGJ8
                                        **HHRG = C0F2S1/Clinical = Min, Functional = Mod, Service = Low**
                                        HAGK1
                                        HAGK2
                                        HAGK3
                                        HAGK4
                                        HAGK5
                                        HAGK6
                                        HAGK7
                                        HAGK8
                                        **HHRG = C0F2S2/Clinical = Min, Functional = Mod, Service = Mod**
                                        HAGL1
                                        HAGL2
                                        HAGL3
                                        HAGL4
                                        HAGL5
                                        HAGL6
                                        HAGL7
                                        HAGL8
                                        **HHRG = C0F2S3/Clinical = Min, Functional = Mod, Service = High**
                                        HAGM1
                                        HAGM2
                                        HAGM3
                                        HAGM4
                                        HAGM5
                                        HAGM6
                                        HAGM7
                                        HAGM8
                                        **HHRG = C0F3S0/Clinical = Min, Functional = High, Service = Min**
                                        HAHJ1
                                        HAHJ2
                                        HAHJ3
                                        HAHJ4
                                        HAHJ5
                                        HAHJ6
                                        HAHJ7
                                        HAHJ8
                                        **HHRG = C0F3S1/Clinical = Min, Functional = High, Service = Low**
                                        HAHK1
                                        HAHK2
1         CLM_HIPPS_TB                  Claim SNF & HHA Health Insurance      PPS Table
          ------------                  ------------------------------------------------

                                        HAHK3
                                        HAHK4
                                        HAHK5
                                        HAHK6
                                        HAHK7
                                        HAHK8
                                        **HHRG = C0F3S2/Clinical = Min, Functional = High, Service = Mod**
                                        HAHL1
                                        HAHL2
                                        HAHL3
                                        HAHL4
                                        HAHL5
```

```
                                HAHL6
                                HAHL7
                                HAHL8
                                **HHRG = C0F3S3/Clinical = Min, Functional = High, Service = High**
                                HAHM1
                                HAHM2
                                HAHM3
                                HAHM4
                                HAHM5
                                HAHM6
                                HAHM7
                                HAHM8
                                **HHRG = C0F4S0/Clinical = Min, Functional = Max, Service = Min**
                                HAIJ1
                                HAIJ2
                                HAIJ3
                                HAIJ4
                                HAIJ5
                                HAIJ6
                                HAIJ7
                                HAIJ8
                                **HHRG = C0F4S1/Clinical = Min, Functional = Max, Service = Low**
                                HAIK1
                                HAIK2
                                HAIK3
                                HAIK4
                                HAIK5
                                HAIK6
                                HAIK7
                                HAIK8
                                **HHRG = C0F4S2/Clinical = Min, Functional = Max, Service = Mod**
                                HAIL1
                                HAIL2
                                HAIL3
                                HAIL4
                                HAIL5
                                HAIL6
                                HAIL7
                                HAIL8
                                **HHRG = C0F4S3/Clinical = Min, Functional = Max, Service = High**
                                HAIM1
                                HAIM2
                                HAIM3
                                HAIM4
                                HAIM5
                                HAIM6
1        CLM_HIPPS_TB                 Claim SNF & HHA Health Insurance      PPS Table
         -----------                  ------------------------------------------------

                                HAIM7
                                HAIM8
                                **HHRG = C1F0S0/Clinical = Low, Functional = Min, Service = Min**
                                HBEJ1
                                HBEJ2
                                HBEJ3
                                HBEJ4
                                HBEJ5
                                HBEJ6
```

```
                              HBEJ7
                              HBEJ8
                              **HHRG = C1F0S1/Clinical = Low, Functional = Min, Service = Low**
                              HBEK1
                              HBEK2
                              HBEK3
                              HBEK4
                              HBEK5
                              HBEK6
                              HBEK7
                              HBEK8
                              **HHRG = C1F0S2/Clinical = Low, Functional = Min, Service = Mod**
                              HBEL1
                              HBEL2
                              HBEL3
                              HBEL4
                              HBEL5
                              HBEL6
                              HBEL7
                              HBEL8
                              **HHRG = C1F0S3/Clinical = Low, Functional = Min, Service = High**
                              HBEM1
                              HBEM2
                              HBEM3
                              HBEM4
                              HBEM5
                              HBEM6
                              HBEM7
                              HBEM8
                              **HHRG = C1F1S0/Clinical = Low, Functional = Low, Service = Min**
                              HBFJ1
                              HBFJ2
                              HBFJ3
                              HBFJ4
                              HBFJ5
                              HBFJ6
                              HBFJ7
                              HBFJ8
                              **HHRG = C1F1S1/Clinical = Low, Functional = Low, Service = Low**
                              HBFK1
                              HBFK2
                              HBFK3
                              HBFK4
                              HBFK5
                              HBFK6
                              HBFK7
                              HBFK8
                              **HHRG = C1F1S2/Clinical = Low, Functional = Low, Service = Mod**
                              HBFL1
1        CLM_HIPPS_TB                 Claim SNF & HHA Health Insurance      PPS Table
         ------------                 -------------------------------------------------

                              HBFL2
                              HBFL3
                              HBFL4
                              HBFL5
                              HBFL6
                              HBFL7
```

```
                                      HBFL8
                                      **HHRG = C1F1S3/Clinical = Low, Functional = Low, Service = High**
                                      HBFM1
                                      HBFM2
                                      HBFM3
                                      HBFM4
                                      HBFM5
                                      HBFM6
                                      HBFM7
                                      HBFM8
                                      **HHRG = C1F2S0/Clinical = Low, Functional = Mod, Service = Min**
                                      HBGJ1
                                      HBGJ2
                                      HBGJ3
                                      HBGJ4
                                      HBGJ5
                                      HBGJ6
                                      HBGJ7
                                      HBGJ8
                                      **HHRG = C1F2S1/Clinical = Low, Functional = Mod, Service = Low**
                                      HBGK1
                                      HBGK2
                                      HBGK3
                                      HBGK4
                                      HBGK5
                                      HBGK6
                                      HBGK7
                                      HBGK8
                                      **HHRG = C1F2S2/Clinical = Low, Functional = Mod, Service = Mod**
                                      HBGL1
                                      HBGL2
                                      HBGL3
                                      HBGL4
                                      HBGL5
                                      HBGL6
                                      HBGL7
                                      HBGL8
                                      **HHRG = C1F2S3/Clinical = Low, Functional = Mod, Service = High**
                                      HBGM1
                                      HBGM2
                                      HBGM3
                                      HBGM4
                                      HBGM5
                                      HBGM6
                                      HBGM7
                                      HBGM8
                                      **HHRG = C1F3S0/Clinical = Low, Functional = High, Service = Min**
                                      HBHJ1
                                      HBHJ2
                                      HBHJ3
                                      HBHJ4
                                      HBHJ5
1        CLM_HIPPS_TB                 Claim SNF & HHA Health Insurance      PPS Table
         ------------                 -------------------------------------------------

                                      HBHJ6
                                      HBHJ7
                                      HBHJ8
```

```
                         **HHRG = C1F3S1/Clinical = Low, Functional = High, Service = Low**
                         HBHK1
                         HBHK2
                         HBHK3
                         HBHK4
                         HBHK5
                         HBHK6
                         HBHK7
                         HBHK8
                         **HHRG = C1F3S2/Clinical = Low, Functional = High, Service = Mod**
                         HBHL1
                         HBHL2
                         HBHL3
                         HBHL4
                         HBHL5
                         HBHL6
                         HBHL7
                         HBHL8
                         **HHRG = C1F3S3/Clinical = Low, Functional = High, Service = High**
                         HBHM1
                         HBHM2
                         HBHM3
                         HBHM4
                         HBHM5
                         HBHM6
                         HBHM7
                         HBHM8
                         **HHRG = C1F4S0/Clinical = Low, Functional = Max, Service = Min**
                         HBIJ1
                         HBIJ2
                         HBIJ3
                         HBIJ4
                         HBIJ5
                         HBIJ6
                         HBIJ7
                         HBIJ8
                         **HHRG = C1F4S1/Clinical = Low, Functional = Max, Service = Low**
                         HBIK1
                         HBIK2
                         HBIK3
                         HBIK4
                         HBIK5
                         HBIK6
                         HBIK7
                         HBIK8
                         **HHRG = C1F4S2/Clinical = Low, Functional = Max, Service = Mod**
                         HBIL1
                         HBIL2
                         HBIL3
                         HBIL4
                         HBIL5
                         HBIL6
                         HBIL7
                         HBIL8
                         **HHRG = C1F4S3/Clinical = Low, Functional = Max, Service = High**
1        CLM_HIPPS_TB                    Claim SNF & HHA Health Insurance        PPS Table
         ------------                    -------------------------------------------------
```

```
HBIM1
HBIM2
HBIM3
HBIM4
HBIM5
HBIM6
HBIM7
HBIM8
**HHRG = C2F0S0/Clinical = Mod, Functional = Min, Service = Min**
HCEJ1
HCEJ2
HCEJ3
HCEJ4
HCEJ5
HCEJ6
HCEJ7
HCEJ8
**HHRG = C2F0S1/Clinical = Mod, Functional = Min, Service = Low**
HCEK1
HCEK2
HCEK3
HCEK4
HCEK5
HCEK6
HCEK7
HCEK8
**HHRG = C2F0S2/Clinical = Mod, Functional = Min, Service = Mod**
HCEL1
HCEL2
HCEL3
HCEL4
HCEL5
HCEL6
HCEL7
HCEL8
**HHRG = C2F0S3/Clinical = Mod, Functional = Min, Service = High**
HCEM1
HCEM2
HCEM3
HCEM4
HCEM5
HCEM6
HCEM7
HCEM8
**HHRG = C2F1S0/Clinical = Mod, Functional = Low, Service = Min**
HCFJ1
HCFJ2
HCFJ3
HCFJ4
HCFJ5
HCFJ6
HCFJ7
HCFJ8
**HHRG = C2F1S2/Clinical = Mod, Functional = Low, Service = Mod**
HCFL1
HCFL2
HCFL3
HCFL4
```

```
                                     HCFL5
                                     HCFL6
                                     HCFL7
                                     HCFL8
                                     **HHRG = C2F1S3/Clinical = Mod, Functional = Low, Service = High**
                                     HCFM1
                                     HCFM2
                                     HCFM3
                                     HCFM4
                                     HCFM5
                                     HCFM6
                                     HCFM7
                                     HCFM8
                                     **HHRG = C2F2S0/Clinical = Mod, Functional = Mod, Service = Min**
                                     HCGJ1
                                     HCGJ2
                                     HCGJ3
                                     HCGJ4
                                     HCGJ5
                                     HCGJ6
                                     HCGJ7
                                     HCGJ8
                                     **HHRG = C2F2S1/Clinical = Mod, Functional = Mod, Service = Low**
                                     HCGK1
                                     HCGK2
                                     HCGK3
                                     HCGK4
                                     HCGK5
                                     HCGK6
                                     HCGK7
                                     HCGK8
                                     **HHRG = C2F2S2/Clinical = Mod, Functional = Mod, Service = Mod**
                                     HCGL1
                                     HCGL2
                                     HCGL3
                                     HCGL4
                                     HCGL5
                                     HCGL6
                                     HCGL7
                                     HCGL8
                                     **HHRG = C2F2S3/Clinical = Mod, Functional = Mod, Service = High**
                                     HCGM1
                                     HCGM2
                                     HCGM3
                                     HCGM4
                                     HCGM5
                                     HCGM6
                                     HCGM7
                                     HCGM8
                                     **HHRG = C2F3S0/Clinical = Mod, Functional = High, Service = Min**
                                     HCHJ1
                                     HCHJ2
                                     HCHJ3
                                     HCHJ4
                                     HCHJ5
```

```
                                   HCHJ6
                                   HCHJ7
                                   HCHJ8
1          CLM_HIPPS_TB                    Claim SNF & HHA Health Insurance        PPS Table
           ------------                    ---------------------------------------------

                                   **HHRG = C2F3S1/Clinical = Mod, Functional = High, Service = Low**
                                   HCHK1
                                   HCHK2
                                   HCHK3
                                   HCHK4
                                   HCHK5
                                   HCHK6
                                   HCHK7
                                   HCHK8
                                   **HHRG = C2F3S2/Clinical = Mod, Functional = High, Service = Mod**
                                   HCHL1
                                   HCHL2
                                   HCHL3
                                   HCHL4
                                   HCHL5
                                   HCHL6
                                   HCHL7
                                   HCHL8
                                   **HHRG = C2F3S3/Clinical = Mod, Functional = High, Service = High**
                                   HCHM1
                                   HCHM2
                                   HCHM3
                                   HCHM4
                                   HCHM5
                                   HCHM6
                                   HCHM7
                                   HCHM8
                                   **HHRG = C2F4S0/Clinical = Mod, Functional = Max, Service = Min**
                                   HCIJ1
                                   HCIJ2
                                   HCIJ3
                                   HCIJ4
                                   HCIJ5
                                   HCIJ6
                                   HCIJ7
                                   HCIJ8
                                   **HHRG = C2F4S1/Clinical = Mod, Functional = Max, Service = Low**
                                   HCIK1
                                   HCIK2
                                   HCIK3
                                   HCIK4
                                   HCIK5
                                   HCIK6
                                   HCIK7
                                   HCIK8
                                   **HHRG = C2F4S2/Clinical = Mod, Functional = Max, Service = Mod**
                                   HCIL1
                                   HCIL2
                                   HCIL3
                                   HCIL4
                                   HCIL5
                                   HCIL6
```

```
                                   HCIL7
                                   HCIL8
                                   **HHRG = C2F4S3/Clinical = Mod, Functional = Max, Service = High**
                                   HCIM1
                                   HCIM2
                                   HCIM3
1        CLM_HIPPS_TB              Claim SNF & HHA Health Insurance      PPS Table
         ------------              ------------------------------------------------

                                   HCIM4
                                   HCIM5
                                   HCIM6
                                   HCIM7
                                   HCIM8
                                   **HHRG = C3F0S0/Clinical = High, Functional = Min, Service = Min**
                                   HDEJ1
                                   HDEJ2
                                   HDEJ3
                                   HDEJ4
                                   HDEJ5
                                   HDEJ6
                                   HDEJ7
                                   HDEJ8
                                   **HHRG = C3F0S1/Clinical = High, Functional = Min, Service = Low**
                                   HDEK1
                                   HDEK2
                                   HDEK3
                                   HDEK4
                                   HDEK5
                                   HDEK6
                                   HDEK7
                                   HDEK8
                                   **HHRG = C3F0S2/Clinical = High, Functional = Min, Service = Mod**
                                   HDEL1
                                   HDEL2
                                   HDEL3
                                   HDEL4
                                   HDEL5
                                   HDEL6
                                   HDEL7
                                   HDEL8
                                   **HHRG = C3F0S3/Clinical = High, Functional = Min, Service = High**
                                   HDEM1
                                   HDEM2
                                   HDEM3
                                   HDEM4
                                   HDEM5
                                   HDEM6
                                   HDEM7
                                   HDEM8
                                   **HHRG = C3F1S0/Clinical = High, Functional = Low, Service = Min**
                                   HDFJ1
                                   HDFJ2
                                   HDFJ3
                                   HDFJ4
                                   HDFJ5
                                   HDFJ6
                                   HDFJ7
```

```
                                HDFJ8
                                **HHRG = C3F1S1/Clinical = High, Functional = Low, Service = Low**
                                HDFK1
                                HDFK2
                                HDFK3
                                HDFK4
                                HDFK5
                                HDFK6
                                HDFK7
1        CLM_HIPPS_TB                   Claim SNF & HHA Health Insurance      PPS Table
         ------------                   -------------------------------------------------

                                HDFK8
                                **HHRG = C3F1S2/Clinical = High, Functional = Low, Service = Mod**
                                HDFL1
                                HDFL2
                                HDFL3
                                HDFL4
                                HDFL5
                                HDFL6
                                HDFL7
                                HDFL8
                                **HHRG = C3F1S3/Clinical = High, Functional = Low, Service = High**
                                HDFM1
                                HDFM2
                                HDFM3
                                HDFM4
                                HDFM5
                                HDFM6
                                HDFM7
                                HDFM8
                                **HHRG = C3F2S0/Clinical = High, Functional = Mod, Service = Min**
                                HDGJ1
                                HDGJ2
                                HDGJ3
                                HDGJ4
                                HDGJ5
                                HDGJ6
                                HDGJ7
                                HDGJ8
                                **HHRG = C3F2S1/Clinical = High, Functional = Mod, Service = Low**
                                HDGK1
                                HDGK2
                                HDGK3
                                HDGK4
                                HDGK5
                                HDGK6
                                HDGK7
                                HDGK8
                                **HHRG = C3F2S2/Clinical = High, Functional = Mod, Service = Mod**
                                HDGL1
                                HDGL2
                                HDGL3
                                HDGL4
                                HDGL5
                                HDGL6
                                HDGL7
                                HDGL8
```

```
                          **HHRG = C3F2S3/Clinical = High, Functional = Mod, Service = High**
                          HDGM1
                          HDGM2
                          HDGM3
                          HDGM4
                          HDGM5
                          HDGM6
                          HDGM7
                          HDGM8
                          **HHRG = C3F3S0/Clinical = High, Functional = High, Service = Min**
                          HDHJ1
                          HDHJ2
1       CLM_HIPPS_TB              Claim SNF & HHA Health Insurance      PPS Table
        ------------              ------------------------------------------------

                          HDHJ3
                          HDHJ4
                          HDHJ5
                          HDHJ6
                          HDHJ7
                          HDHJ8
                          **HHRG = C3F3S1/Clinical = High, Functional = High, Service = Low**
                          HDHK1
                          HDHK2
                          HDHK3
                          HDHK4
                          HDHK5
                          HDHK6
                          HDHK7
                          HDHK8
                          **HHRG = C3F3S2/Clinical = High, Functional = High, Service = Mod**
                          HDHL1
                          HDHL2
                          HDHL3
                          HDHL4
                          HDHL5
                          HDHL6
                          HDHL7
                          HDHL8
                          **HHRG = C3F3S3/Clinical = High, Functional = High, Service = High**
                          HDHM1
                          HDHM2
                          HDHM3
                          HDHM4
                          HDHM5
                          HDHM6
                          HDHM7
                          HDHM8
                          **HHRG = C3F4S0/Clinical = High, Functional = Max, Service = Min**
                          HDIJ1
                          HDIJ2
                          HDIJ3
                          HDIJ4
                          HDIJ5
                          HDIJ6
                          HDIJ7
                          HDIJ8
                          **HHRG = C3F4S1/Clinical = High, Functional = Max, Service = Low**
```

```
                          HDIK1
                          HDIK2
                          HDIK3
                          HDIK4
                          HDIK5
                          HDIK6
                          HDIK7
                          HDIK8
                          **HHRG = C3F4S2/Clinical = High, Functional = Max, Service = Mod**
                          HDIL1
                          HDIL2
                          HDIL3
                          HDIL4
                          HDIL5
                          HDIL6
1      CLM_HIPPS_TB               Claim SNF & HHA Health Insurance      PPS Table
       ------------               ------------------------------------------------

                          HDIL7
                          HDIL8
                          **HHRG = C3F4S3/Clinical = High, Functional = Max, Service = High**
                          HDIM1
                          HDIM2
                          HDIM3
                          HDIM4
                          HDIM5
                          HDIM6
                          HDIM7
                          HDIM8

1      CLM_IP_ADMSN_TYPE_TB                Claim Inpatient Admission Type Table
       --------------------                ------------------------------------


                          0 = Blank
                          1 = Emergency - The patient required
                              immediate medical intervention as a
                              result of severe, life threatening, or
                              potentially disabling conditions.
                              Generally, the patient was admitted
                              through the emergency room.
                          2 = Urgent - The patient required immediate
                              attention for the care and treatment
                              of a physical or mental disorder.
                              Generally, the patient was admitted to
                              the first available and suitable
                              accommodation.
                          3 = Elective - The patient's condition
                              permitted adequate time to schedule the
                              availability of suitable accommodations.
                          4 = Newborn - Necessitates the use of
                              special source of admission codes.

                          5 THRU 8 =  Reserved.
                          9 =  Unknown - Information not available.

1      CLM_MDCR_NPMT_RSN_TB                Claim Medicare Non-Payment Reason Table
       --------------------                ---------------------------------------
```

```
                        A = Covered worker's compensation (Obsolete)
                        B = Benefit exhausted
                        C = Custodial care - noncovered care
                            (includes all 'beneficiary at fault'
                            waiver cases) (Obsolete)
                        E = HMO out-of-plan services not emergency
                            or urgently needed (Obsolete)
                        E = MSP cost avoided - IRS/SSA/HCFA Data
                            Match (eff. 7/00)
                        F = MSP cost avoid HMO Rate Cell (eff. 7/00)
                        G = MSP cost avoided Litigation Settlement
                            (eff. 7/00)
                        H = MSP cost avoided Employer Voluntary
                            Reporting (eff. 7/00)
                        J = MSP cost avoid Insurer Voluntary
                            Reporting (eff. 7/00)
                        K = MSP cost avoid Initial Enrollment
                            Questionnaire (eff. 7/00)
                        N = All other reasons for nonpayment
                        P = Payment requested
                        Q = MSP cost avoided Voluntary Agreement
                            (eff. 7/00)
                        R = Benefits refused, or evidence not
                            submitted
                        T = MSP cost avoided - IEQ contractor
                            (eff. 9/76) (obsolete 6/30/00)
                        U = MSP cost avoided - HMO rate cell
                            adjustment (eff. 9/76) (Obsolete 6/30/00)
                        V = MSP cost avoided - litigation
                            settlement (eff. 9/76) (Obsolete 6/30/00)
                        W = Worker's compensation (Obsolete)
                        X = MSP cost avoided - generic
                        Y = MSP cost avoided - IRS/SSA data
                            match project (obsolete 6/30/00)
                        Z = Zero reimbursement RAPs -- zero reimbursement
                            made due to medical review intervention or
                            where provider specific zero payment has been
                            determined. (effective with HHPPS - 10/00)
```

1   CLM_OCRNC_SPAN_TB   Claim Occurrence Span Table
      -----------------   ---------------------------

```
                        70 = Eff 10/93, payer use only, the
                             nonutilization from/thru dates
                             for PPS-inlier stay where bene had
                             exhausted all full/coinsurance days, but
                             covered on cost report.
                             SNF qualifying hospital stay from/thru dates
                        71 = Hospital prior stay dates - the from/
                             thru dates of any hospital stay that
                             ended within 60 days of this hospital
                             or SNF admission.
                        72 = First/last visit - the dates of the
                             first and last visits occurring in this
                             billing period if the dates are different
```

```
                              from those in the statement covers period.
                  73 = Benefit eligibility period - the
                              inclusive dates during which CHAMPUS
                              medical benefits are available to a
                              sponsor's bene as shown on the
                              bene's ID card.
                  74 = Non-covered level of care - The from/
                              thru dates of a period at a noncovered
                              level of care in an otherwise
                              covered stay, excluding any period
                              reported with occurrence span code 76,
                              77, or 79.
                  75 = The from/thru dates of SNF level of care
                              during IP hospital stay.  Shows PRO approval
                              of patient remaining in hospital
                              because SNF bed not available.
                              not applicable to swing bed
                              cases. PPS hospitals use in day
                              outlier cases only.
                  76 = Patient liability - From/thru
                              dates of period of noncovered care
                              for which hospital may charge
                              bene. The FI or PRO must have
                              approved such charges in advance.
                              patient must be notified in writing
                              3 days prior to noncovered period
                  77 = Provider liability - The from/thru
                              dates of period of noncovered care
                              for which the provider is liable.
                              Eff 3/92, applies to provider liability
                              where bene is charged with utilization
                              and is liable for deductible/coinsurance
                  78 = SNF prior stay dates - The from/
                              thru dates of any SNF stay that
                              ended within 60 days of this hospital
                              or SNF admission.
                  79 = (Payer code) -
                              Eff 3/92, from/thru dates of
                              period of noncovered care where
                              bene is not charged with utilization,
                              deductible, or coinsurance.
                              and provider is liable.
                              Eff 9/93, noncovered period of care
                              due to lack of medical necessity.
1      CLM_OCRNC_SPAN_TB                      Claim Occurrence Span Table
       -----------------                      ---------------------------

                  80 - 99 = Reserved for state assignment
                  M0 = PRO/UR approved stay dates - Eff 10/93,
                              the first and last days that were
                              approved where not all of the stay was
                              approved.

1      CLM_PPS_IND_TB                         Claim PPS Indicator Table
       --------------                         -------------------------


            ***Effective NCH weekly process date 10/3/97 - 5/29/98***
```

```
                    0 = not PPS bill (claim contains no PPS indicator)
                    2 = PPS bill ( claim contains PPS indicator)

                    ***Effective NCH weekly process date 6/5/98***

                    0 = not applicable (claim contains neither PPS
                        nor deemed insured MQGE status indicators)
                    1 = Deemed insured MQGE (claim contains deemed
                        insured MQGE indicator but not PPS indicator)
                    2 = PPS bill ( claim contains PPS indicator but no
                        deemed insured MQGE status indicator)
                    3 = Both PPS and deemed insured MQGE (contains both
                        PPS and deemed insured MQGE indicators)

1      CLM_RLT_COND_TB                      Claim Related Condition Table
       ---------------                      ----------------------------


                    01 = Military service related - Medical
                         condition incurred during military
                         service.
                    02 = Employment related - Patient alleged
                         that the medical condition causing this
                         episode of care was due to environment/
                         events resulting from employment.
                    03 = Patient covered by insurance not
                         reflected here - Indicates that patient
                         or patient representative has stated
                         that coverage may exist beyond that
                         reflected on this bill.
                    04 = Health Maintenance Organization (HMO)
                         enrollee - Medicare beneficiary is
                         enrolled in an HMO.  Eff 9/93, hospital
                         must also expect to receive payment
                         from HMO.
                    05 = Lien has been filed - Provider has
                         filed legal claim for recovery of funds
                         potentially due a patient as a result
                         of legal action initiated by or on
                         behalf of the patient.
                    06 = ESRD patient in 1st 18 months of entitlement
                         covered by employer group health insurance -
                         indicates Medicare may be secondary
                         insurer.  Eff 3/1/96, ESRD patient in 1st
                         30 months of entitlement covered by employer
                         group health insurance.
                    07 = Treatment of nonterminal condition for
                         hospice patient - The patient is a
                         hospice enrollee, but the provider is
                         not treating a terminal condition and
                         is requesting Medicare reimbursement.
                    08 = Beneficiary would not provide information
                         concerning other insurance coverage.
                    09 = Neither patient nor spouse is employed
                         - Code indicates that in response to
                         development questions, the patient and
                         spouse have denied employment.
```

```
                               10 = Patient and/or spouse is employed but
                                    no EGHP coverage exists or (eff 9/93)
                                    other employer sponsored/provided
                                    health insurance covering patient.
                               11 = The disabled beneficiary and/or family
                                    member has no group coverage from a LGHP
                                    or (eff 9/93) other employer
                                    sponsored/provided health insurance
                                    covering patient.
                               12 = Payer code - Reserved for internal
                                    use only by third party payers.  HCFA
                                    will assign as needed.  Providers will
                                    not report them.
                               13 = Payer code - Reserved for internal
                                    use only by third party payers.  HCFA
                                    will assign as needed.  Providers will
                                    not report them.
                               14 = Payer code - Reserved for internal
1       CLM_RLT_COND_TB                     Claim Related Condition Table
        --------------                      ---------------------------

                                    use only by third party payers.  HCFA
                                    will assign as needed.  Providers will
                                    not report them.
                               15 = Clean claim (eff 10/92)
                               16 = SNF transition exemption - An
                                    exemption from the post-hospital
                                    requirement applies for this SNF stay
                                    or the qualifying stay dates are more
                                    than 30 days prior to the admission date
                               17 = Patient is over 100 years old - Code
                                    indicates that the patient was over
                                    100 years old at the date of admission.
                               18 = Maiden name retained - A dependent
                                    spouse entitled to benefits who does
                                    not use her husband's last name.
                               19 = Child retains mother's name - A
                                    patient who is a dependent child
                                    entitled to CHAMPVA benefits that does
                                    not have father's last name.
                               20 = Bene requested billing - Provider
                                    realizes the services on this bill are at a
                                    noncovered level of care or otherwise excluded
                                    from coverage, but the bene has requested
                                    formal determination
                               21 = Billing for denial notice - The SNF or HHA
                                    realizes services are at a noncovered level of
                                    care or excluded, but requests a Medicare denial
                                    in order to bill medicaid or other insurer
                               22 = Patient on multiple drug regimen - A
                                    patient who is receiving multiple
                                    intravenous drugs while on home IV
                                    therapy
                               23 = Homecaregiver available - The patient
                                    has a caregiver available to assist him
                                    or her during self-administration of an
                                    intravenous drug
                               24 = Home IV patient also receiving HHA
```

```
                              services - the patient is under care
                              of HHA while receiving home IV drug
                              therapy services
                         25 = Reserved for national assignment
                         26 = VA eligible patient chooses to
                              receive services in Medicare certified
                              facility rather than a VA facility
                              (eff 3/92)
                         27 = Patient referred to a sole community
                              hospital for a diagnostic laboratory
                              test - (sole community hospital only).
                              (eff 9/93)
                         28 = Patient and/or spouse's EGHP is
                              secondary to Medicare -
                              Qualifying EGHP for employers who have
                              fewer than 20 employees. (eff 9/93)
                         29 = Disabled beneficiary and/or family
                              member's LGHP is secondary to
                              Medicare - Qualifying LGHP for
                              employer having fewer than 100 full and
                              part-time employees
1       CLM_RLT_COND_TB                    Claim Related Condition Table
        ---------------                    -----------------------------

                         31 = Patient is student (full time - day) -
                              Patient declares that he or she is
                              enrolled as a full time day student.
                         32 = Patient is student (cooperative/work
                              study program)
                         33 = Patient is student (full time - night)
                              - Patient declares that he or she is
                              enrolled as a full time night student.
                         34 = Patient is student (part time) -
                              Patient declares that he or she is
                              enrolled as a part time student.
                         36 = General care patient in a special
                              unit - Patient is temporarily placed in
                              special care unit bed because no
                              general care beds were available.
                         37 = Ward accommodation is patient's
                              request - Patient is assigned to ward
                              accommodations at patient's request.
                         38 = Semi-private room not available -
                              Indicates that either private or ward
                              accommodations were assigned because
                              semi-private accomodations were not
                              available.
                         39 = Private room medically necessary -
                              Patient needed a private room for
                              medical reasons.
                         40 = Same day transfer - Patient
                              transferred to another facility
                              before midnight of the day of admission.
                         41 = Partial hospitalization - Eff 3/92,
                              indicates claim is for partial
                              hospitalization services.  For OP
                              services, this includes a variety
                              of psych programs.
```

```
                         42 = Reserved for national assignment.
                         43 = Reserved for national assignment.
                         44 = Reserved for national assignment.
                         45 = Reserved for national assignment.
                         46 = Nonavailability statement on file for
                              CHAMPUS claim for nonemergency IP care
                              for CHAMPUS bene residing within the
                              catchment area (usually a 40 mile
                              radius) of a uniform services hospital.
                         47 = Reserved for CHAMPUS.
                         48 = Reserved for national assignment.
                         49 = Reserved for national assignment.
                         50 = Reserved for national assignment.
                         51 = Reserved for national assignment.
                         52 = Reserved for national assignment.
                         53 = Reserved for national assignment.
                         54 = Reserved for national assignment.
                         55 = SNF bed not available - The patient's
                              SNF admission was delayed more than 30
                              days after hospital discharge because
                              a SNF bed was not available.
                         56 = Medical appropriateness - Patient's
                              SNF admission was delayed more than 30
                              days after hospital discharge because
1       CLM_RLT_COND_TB                     Claim Related Condition Table
        ---------------                     -----------------------------

                              physical condition made it inappropriate
                              to begin active care within that period
                         57 = SNF readmission - Patient previously
                              received Medicare covered SNF care
                              within 30 days of the current SNF
                              admission.
                         58 = Payment of SNF claims for beneficiaries
                              disenrolling from terminating M+C plans
                              plans who have not met the 3-day hospital
                              stay requirement (eff. 10/1/00)
                         59 = Reserved for national assignment.
                         60 = Operating cost day outlier - PRICER
                              indicates this bill is length of stay
                              outlier (PPS)
                         61 = Operating cost cost outlier - PRICER
                              indicates this bill is a cost outlier
                              (PPS)
                         62 = PIP bill - This bill is a periodic
                              interim payment bill.
                         63 = PRO denial received before batch
                              clearance report - The HCSSACL receipt date
                              is used on PRO adjustment if the PRO's
                              notification is before orig bill's acceptance
                              report. (Payer only code eff 9/93)
                         64 = Other than clean claim - The claim is
                              not a 'clean claim'
                         65 = Non-PPS code - The bill is not a
                              prospective payment system bill.
                         66 = Outlier not claimed - Bill may meet
                              the criteria for cost outlier, but the
                              hospital did not claim the cost outlier
```

```
                   (PPS)
              67 = Beneficiary elects not to use LTR days
              68 = Beneficiary elects to use LTR days
              69 = Operating IME Payment Only - providers
                   request for IME payment for each discharge
                   of MCO enrollee, beginning 1/1/98, from
                   teaching hospitals (facilities with approved
                   medical residency training program); not
                   stored in NCH.  Exception:  problem in
                   startup year may have resulted in this
                   special IME payment request being erroneously
                   stored in NCH.  If present, disregard claim
                   as condition code '69' is not valid NCH
                   claim.
              70 = Self-administered EPO - Billing is
                   for a home dialysis patient who self
                   administers EPO.
              71 = Full care in unit - Billing is for a
                   patient who received staff assisted
                   dialysis services in a hospital or
                   renal dialysis facility.
              72 = Self care in unit - Billing is for a
                   patient who managed his own dialysis
                   services without staff assistance in a
                   hospital or renal dialysis facility.
              73 = Self care training - Billing is for
                   special dialysis services where the
1     CLM_RLT_COND_TB                  Claim Related Condition Table
      ---------------                  ----------------------------

                   patient and helper (if necessary) were
                   learning to perform dialysis.
              74 = Home - Billing is for a patient who
                   received dialysis services at home.
              75 = Home 100% reimbursement -
                   (not to be used for services after 4/15/90)
                   The billing is for home dialsis patient using
                   a dialysis machine that was purchased
                   under the 100% program.
              76 = Back-up facility - Billing is for a
                   patient who received dialysis services
                   in a back-up facility.
              77 = Provider accepts or is obligated/
                   required due to contractual agreement
                   or law to accept payment by a primary
                   payer as payment in full - Medicare
                   pays nothing.
              78 = New coverage not implemented by HMO -
                   eff 3/92, indicates newly covered
                   service under Medicare for which HMO
                   does not pay.
              79 = CORF services provided off site -
                   Code indicates that physical therapy,
                   occupational therapy, or speech path-
                   ology services were provided off site.
              80 - 99 = Reserved for state assignment.
              A0 = CHAMPUS external partnership program
                   special program indicator code. (eff 10/93)
```

```
                           A1 = EPSDT/CHAP - Early and periodic
                                screening diagnosis and treatment
                                special program indicator code. (eff 10/93)
                           A2 = Physically handicapped children's
                                program - Services provided receive
                                special funding through Title 8 of
                                the Social Security Act or the CHAMPUS
                                program for the handicapped. (eff 10/93)
                           A3 = Special federal funding - Designed for
                                uniform use by state uniform billing
                                committees.
                                Special program indicator code (eff 10/93)
                           A4 = Family planning - Designed for
                                uniform use by state uniform billing
                                committees.
                                Special program indicator code (eff 10/93)
                           A5 = Disability - Designed for uniform
                                use by state uniform billing
                                committees.
                                Special program indicator code (eff 10/93)
                           A6 = PPV/Medicare - Identifies that
                                pneumococcal pneumonia 100% payment
                                vaccine (PPV) services should be
                                reimbursed under a special Medicare
                                program provision.
                                Special program indicator code (eff 10/93)
                           A7 = Induced abortion to avoid danger to
                                woman's life.
                                Special program indicator code (eff 10/93)
                           A8 = Induced abortion - Victim of rape/
1      CLM_RLT_COND_TB                       Claim Related Condition Table
       --------------                        ----------------------------

                                incest.
                                Special program indicator code (eff 10/93)
                           A9 = Second opinion surgery - Services
                                requested to support second opinion
                                on surgery.  Part B deductible and
                                coinsurance do not apply.
                                Special program indicator code (eff 10/93)
                           B0 = Special program indicator
                                Reserved for national assignment.
                           B1 = Special program indicator
                                Reserved for national assignment.
                           B2 = Special program indicator
                                Reserved for national assignment.
                           B3 = Special program indicator
                                Reserved for national assignment.
                           B4 = Special program indicator
                                Reserved for national assignment.
                           B5 = Special program indicator
                                Reserved for national assignment.
                           B6 = Special program indicator
                                Reserved for national assignment.
                           B7 = Special program indicator
                                Reserved for national assignment.
                           B8 = Special program indicator
                                Reserved for national assignment.
```

```
                        B9 = Special program indicator
                             Reserved for national assignment.
                        C0 = Reserved for national assignment.
                        C1 = Approved as billed - The services
                             provided for this billing period have
                             been reviewed by the PRO/UR or
                             intermediary and are fully approved
                             including any day or cost outlier. (eff 10/93)
                        C2 = Automatic approval as billed based on
                             focused review.  (No longer used for
                             Medicare)
                             PRO approval indicator services (eff 10/93)
                        C3 = Partial approval - The services
                             provided for this billing period have
                             been reviewed by the PRO/UR or
                             intermediary and some portion has been
                             denied (days or services). (eff 10/93)
                        C4 = Admission/services denied - Indicates
                             that all of the services were denied
                             by the PRO/UR.
                             PRO approval indicator services (eff 10/93)
                        C5 = Postpayment review applicable - PRO/UR
                             review to take place after payment.
                             PRO approval indicator services (eff 10/93)
                        C6 = Admission preauthorization - The
                             PRO/UR authorized this admission/
                             service but has not reviewed the
                             services provided.
                             PRO approval indicator services (eff 10/93)
                        C7 = Extended authorization - the PRO has
                             authorized these services for an
                             extended length of time but has not
                             reviewed the services provided.
1       CLM_RLT_COND_TB                         Claim Related Condition Table
        ---------------                         ----------------------------

                             PRO approval indicator services (eff 10/93)
                        C8 = Reserved for national assignment.
                             PRO approval indicator services (eff 10/93)
                        C9 = Reserved for national assignment.
                             PRO approval indicator services (eff 10/93)
                        D0 = Changes to service dates.
                             Change condition (eff 10/93)
                        D1 = Changes in charges.
                             Change condition (eff 10/93)
                        D2 = Changes in revenue codes/HCPCS.
                             Change condition (eff 10/93)
                        D3 = Second or subsequent interim
                             PPS bill.
                             Change condition (eff 10/93)
                        D4 = Change in grouper input (diagnosis
                             and/or procedures are changed resulting
                             in a different DRG).
                             Change condition (eff 10/93)
                        D5 = Cancel only to correct a beneficiary
                             claim account number or provider
                             identification number.
                             change condition (eff 10/93)
```

```
                     D6 = Cancel only to repay a duplicate
                          payment or OIG overpayment (includes
                          cancellation of an OP bill containing
                          services required to be included on the
                          IP bill). Change condition eff 10/93.
                     D7 = Change to make Medicare the secondary
                          payer.
                          Change condition (eff 10/93)
                     D8 = Change to make Medicare the primary
                          payer.
                          Change condition (eff 10/93)
                     D9 = Any other change.
                          Change condition (eff 10/93)
                     E0 = Change in patient status.
                          Change condition (eff 10/93)
                     EY = National Emphysema Treatment Trial (NETT)
                          or Lung Volume Reduction Surgery (LVRS)
                          clinical study (eff. 11/97)
                     G0 = Multiple medical visits occur on the same
                          day in the same revenue center but visits
                          are distinct and constitute independent
                          visits (allows for payment under outpatient
                          PPS -- eff. 7/3/00).
                     M0 = All inclusive rate for outpatient services.
                          (payer only code)
                     M1 = Roster billed influenza virus vaccine.
                          (payer only code)
                          Eff 10/96, also includes pneumoccocal
                          pneumonia vaccine (PPV)
                     M2 = HH override code - home health total
                          reimbursement exceeds the $150,000 cap
                          or the number of total visits exceeds the
                          150 limitation. (eff 4/3/95)
                          (payer only code)
                     W0 = United Mine Workers of America (UMWA)
                          SNF demonstration indicator (eff 1/97);
1       CLM_RLT_COND_TB                  Claim Related Condition Table
        ---------------                  -----------------------------


                     but no claims transmitted until 2/98)


1       CLM_RLT_OCRNC_TB                 Claim Related Occurrence Table
        ----------------                 ------------------------------


                     01 = Auto accident - The date of an auto
                          accident.
                     02 = No-fault insurance involved, including
                          auto accident/other - The date of an
                          accident where the state has applicable
                          no-fault liability laws, (i.e., legal
                          basis for settlement without admission
                          or proof of guilt).
                     03 = Accident/tort liability - The date of
                          an accident resulting from a third
                          party's action that may involve a civil
                          court process in an attempt to require
                          payment by the third party, other than
```

```
                      no-fault liability.
         04 = Accident/employment related - The
              date of an accident relating to the
              patient's employment.
         05 = Other accident - The date of an accident
              not described by the codes 01 thru 04.
         06 = Crime victim - Code indicating the
              date on which a medical condition
              resulted from alleged criminal action
              committed by one or more parties.
         07 = Reserved for national assignment.
         08 = Reserved for national assignment.
         11 = Onset of symptoms/illness - The date
              the patient first became aware of
              symptoms/illness.
         12 = Date of onset for a chronically
              dependent individual - Code indicates
              the date the patient/bene became
              a chronically dependent individual.
         13 = Reserved for national assignment.
         14 = Reserved for national assignment.
         15 = Reserved for national assignment.
         16 = Reserved for national assignment.
         17 = Date outpatient occupational therapy
              plan established or last reviewed -
              Code indicating the date an occupational
              therapy plan was established or
              last reviewed (eff 3/93)
         18 = Date of retirement (patient/bene)
              - Code indicates the date of retirement
              for the patient/bene.
         19 = Date of retirement spouse -
              Code indicates the date of retirement
              for the patient's spouse.
         20 = Guarantee of payment began - The date
              on which the provider began claiming
              Medicare payment under the guarantee
              of payment provision.
         21 = UR notice received - Code indicating
              the date of receipt by the hospital
              of the UR committee's finding that the
              admission or future stay was not
              medically necessary.
         22 = Active care ended - The date on which
1        CLM_RLT_OCRNC_TB                 Claim Related Occurrence Table
         ----------------                 -----------------------------

              a covered level of care ended in a SNF
              or general hospital, or date active care
              ended in a psychiatric or tuberculosis
              hospital.  (For use by intermediary only)
         23 = Reserved for national assignment
              (eff 10/93).
              Benefits exhausted - The last date
              for which benefits can be paid.
              (term 9/30/93; replaced by code A3)
         24 = Date insurance denied - The date the
              insurer's denial of coverage was
```

```
                           received by a higher priority payer.
                    25 = Date benefits terminated by primary
                           payer - The date on which coverage
                           (including worker's compensation benefits
                           or no-fault coverage) is no longer
                           available to the patient.
                    26 = Date skilled nursing facility (SNF)
                           bed available - The date on which a SNF
                           bed became available to a hospital
                           inpatient who required only SNF level of
                           care.
                    27 = Date home health plan established or
                           last reviewed - Code indicating the
                           date a home health plan of treatment
                           was established or last reviewed.
                           not used by hospital unless owner of facility
                    28 = Date comprehensive outpatient rehabi-
                           litation plan established or last re-
                           viewed - Code indicating the date a
                           comprehensive outpatient rehabilitation
                           plan was established or last reviewed.
                           not used by hospital unless owner of facility
                    29 = Date OPT plan established or last
                           reviewed - the date a plan of treatment
                           was established for outpatient physical
                           therapy.
                           Not used by hospital unless owner of facility
                    30 = Date speech pathology plan treatment
                           established or last reviewed - The date
                           a speech pathology plan of treatment
                           was established or last reviewed.
                           Not used by hospital unless owner of facility
                    31 = Date bene notified of intent
                           to bill (accommodations) - The date of
                           the notice provided to the patient by
                           the hospital stating that he no longer
                           required a covered level of IP care.
                    32 = Date bene notified of intent
                           to bill (procedures or treatment) - The
                           date of the notice provided to the patient
                           by the hospital stating requested care
                           (diagnostic procedures or treatments) is
                           not considered reasonable or necessary.
                    33 = First day of the Medicare coordination
                           period for ESRD bene - During
                           which Medicare benefits are secondary
                           to benefits payable under an EGHP.
1       CLM_RLT_OCRNC_TB                        Claim Related Occurrence Table
        ----------------                        -----------------------------

                           Required only for ESRD beneficiaries.
                    34 = Date of election of extended care
                           facilities - The date the guest elected
                           to receive extended care services (used
                           by Christian Science Sanatoria only).
                    35 = Date treatment started for physical
                           therapy - Code indicates the date
                           services were initiated by the billing
```

```
                     provider for physical therapy.
        36 = Date of discharge for the IP
             hospital stay when patient
             received a transplant procedure
             - Hospital is billing for
             immunosuppressive drugs.
        37 = The date of discharge
             for the IP hospital stay when
             patient received a noncovered
             transplant procedure - Hospital
             is billing for immunosuppresive drugs.
        38 = Date treatment started for home IV
             therapy - Date the patient was first
             treated in his home for IV therapy.
        39 = Date discharged on a continuous
             course of IV therapy - Date the patient
             was discharged from the hospital on a
             continuous course of IV therapy.
        40 = Scheduled date of admission - The
             date on which a patient will be admitted
             as an inpatient to the hospital.
             (This code may only be used on an
             outpatient claim.)
        41 = The date on which the first
             outpatient diagnostic test was
             performed as part of a pre-admission
             testing (PAT) program.  This code may
             only be used if a date of admission
             was scheduled prior to the administration
             of the test(s).
        42 = Date of discharge/termination of hospice
             care - for the final bill for hospice
             care.  Eff 5/93, definition revised to
             apply only to date patient revoked
             hospice election.
        43 = Reserved for national assignment.
        44 = Date treatment started for occupational
             therapy - Code indicates the date
             services were initiated by the billing
             provider for occupational therapy.
        45 = Date treatment started for speech
             therapy - Code indicates the date
             services were initiated by the billing
             provider for speech therapy.
        46 = Date treatment started for cardiac
             rehabilitation - Code indicates the
             date services were initiated by the
             billing provider for cardiac
             rehabilitation.
        47 = Noncovered Outlier Stay Began- code
```

1   CLM_RLT_OCRNC_TB   Claim Related Occurrence Table
        ----------------   -----------------------------

```
             indicates the date that cost outlier
             status began and no Medicare payment
             will be made because all benefits have
             been exhausted during the inlier stay or
             the beneficiary does not elect to use life
```

```
              time reserve days (to be implemented in
              1999).
      48 = Payer code - Code reserved for
           internal use only by third party
           payers.  HCFA assigns as needed for
           your use.  Providers will not report it.
      49 = Payer code - Code reserved for
           internal use only by third party
           payers.  HCFA assigns as needed for
           your use.  Providers will not report it.
      50 - 69 = Reserved for state assignment
      A1 = Birthdate, Insured A - The birthdate of
           the individual in whose name the insurance
           is carried. (Eff 10/93)
      A2 = Effective date, Insured A policy - A
           code indicating the first date insurance
           is in force. (eff 10/93)
      A3 = Benefits exhausted - Code indicating
           the last date for which benefits are
           available and after which no payment
           can be made to payer A.  (eff 10/93)
      B1 = Birthdate, Insured B - The birthdate of
           the individual in whose name the insurance
           is carried. (eff 10/93)
      B2 = Effective date, Insured B policy - A
           code indicating the first date insurance
           is in force. (eff 10/93)
      B3 = Benefits exhausted - code indicating
           the last date for which benefits are
           available and after which no payment
           can be made to payer B.  (eff 10/93)
      C1 = Birthdate, Insured C - The birthdate of
           the individual in whose name the insurance
           is carried. (eff 10/93)
      C2 = Effective date, Insured C policy - A
           code indicating the first date insurance
           is in force. (eff 10/93)
      C3 = Benefits exhausted - Code indicating
           the last date for which benefits are
           available and after which no payment
           can be made to payer C.  (eff 10/93)
```

1   CLM_SRC_IP_ADMSN_TB   Claim Source Of Inpatient Admission Table
      -------------------   ---

                      For Inpatient/SNF Claims:

      0 = ANOMALY: invalid value, if present,
          translate to '9'
      1 = Physician referral - The patient was
          admitted upon the recommendation of
          a personal physician.
      2 = Clinic referral - The patient was
          admitted upon the recommendation of
          this facility's clinic physician.
      3 = HMO referral - The patient was admitted

```
                    upon the recommendation of an health
                    maintenance organization (HMO)
                    physician.
        4 = Transfer from hospital - The patient
                    was admitted as an inpatient transfer
                    from an acute care facility.
        5 = Transfer from a skilled nursing
                    facility (SNF) - The patient was
                    admitted as an inpatient transfer
                    from a SNF.
        6 = Transfer from another health care
                    facility - The patient was admitted
                    as a transfer from a health care
                    facility other than an acute care
                    facility or SNF.
        7 = Emergency room - The patient was
                    admitted upon the recommendation of
                    this facility's emergency room
                    physician.
        8 = Court/law enforcement - The patient was
                    admitted upon the direction of a
                    court of law or upon the request of
                    a law enforcement agency's
                    representative.
        9 = Information not available -  The means
                    by which the patient was admitted is
                    not known.
        A = Transfer from a Critical Access Hospital -
                    patient was admitted/referred to this
                    facility as a transfer from a Critical
                    Access Hospital.
          ----------------------------------------
              **For Newborn Type of Admission**

        1 = Normal delivery - A baby delivered with
                    out complications.
        2 = Premature delivery - A baby delivered
                    with time and/or weight factors
                    qualifying it for premature status.
        3 = Sick baby - A baby delivered with
                    medical complications, other than those
                    relating to premature status.
        4 = Extramural birth - A baby delivered in
                    a nonsterile environment.
        5-8 = Reserved for national assignment.
```

1	CLM_SRC_IP_ADMSN_TB	Claim Source Of Inpatient Admission Table
	--------------------	--

```
        9 = Information not available.
```

1	CLM_SRVC_CLSFCTN_TYPE_TB	Claim Service Classification Type Table
	------------------------	---------------------------------------

```
              For facility type code 1 thru 6, and 9

        1 = Inpatient (including Part A)
        2 = Hospital based or Inpatient (Part B only)
```

```
                    or home health visits under Part B
          3 = Outpatient (HHA-A also)
          4 = Other (Part B)
          5 = Intermediate care - level I
          6 = Intermediate care - level II
          7 = Subacute Inpatient
                    (formerly Intermediate care - level III)
          8 = Swing beds (used to indicate billing for
                    SNF level of care in a hospital with an
                    approved swing bed agreement)
          9 = Reserved for national assignment

            For facility type code 7

          1 = Rural health
          2 = Hospital based or independent renal
                    dialysis facility
          3 = Free-standing provider based federally
                    qualified health center (eff 10/91)
          4 = Other Rehabilitation Facility (ORF) and
                    Community Mental Health Center (CMHC)
                    (eff 10/91 - 3/97); ORF only (eff. 4/97)
          5 = Comprehensive Rehabilitation Center
                        (CORF)
          6 = Community Mental Health Center (CMHC) (eff 4/97)
          7-8 = Reserved for national assignment
          9 = Other

            For facility type code 8

          1 = Hospice (non-hospital based)
          2 = Hospice (hospital based)
          3 = Ambulatory surgical center in hospital
                    outpatient department
          4 = Freestanding birthing center
          5 = Critical Access Hospital (eff. 10/99)
                    formerly Rural primary care hospital
                    (eff. 10/94)
          6-8 = Reserved for national use
          9 = Other
```

1	CLM_TRANS_TB		Claim Transaction Table
	-----------		----------------------

```
          0 = Religious NonMedical Health Care Institutions (RNHCI)
                    bill (prior to 8/00, Christian Science bill), SNF bill,
                    or state buy-in
          1 = Psychiatric hospital facility bill or dummy psychiatric
          2 = Tuberculosis hospital facility bill
          3 = General care hospital facility bill or dummy LRD
          4 = Regular SNF bill
          5 = Home health agency bill (HHA)
          6 = Outpatient hospital bill
          C = CORF bill - type of OP bill in the HHA bill format
                    (obsoleted 7/98)
          H = Hospice bill
```

04 = Inpatient professional component
     charges which are combined billed -
     For use only by some all inclusive
     rate hospitals. (Eff 9/93)
05 = Professional component included in
     charges and also billed separately to
     carrier - For use on Medicare and
     Medicaid bills if the state requests
     this information.
06 = Medicare blood deductible - Total
     cash blood deductible (Part A blood
     deductible).
07 = Medicare cash deductible (term 9/30/93)
     reserved for national assignment.
     (eff 10/93)
08 = Medicare Part A lifetime reserve amount
     in first calendar year - Lifetime reserve
     amount charged in the year of admission.
     (not stored in NCH until 2/93)
09 = Medicare Part A coinsurance amount in
     the first calendar year - Coinsurance
     amount charged in the year of admission.
     (not stored in NCH until 2/93)
10 = Medicare Part A lifetime reserve amount
     in the second calendar year - Lifetime
     reserve amount charged in the year of
     discharge where the bill spans two
     calendar years.
     (not stored in NCH until 2/93)
11 = Medicare Part A coinsurance amount in
     the second calendar year - Coinsurance
     amount charged in the year of discharge
     where the bill spans two calendar years
     (not stored in NCH until 2/93)
12 = Amount is that portion of
     higher priority EGHP insurance payment
     made on behalf of aged bene
     provider applied to Medicare
     covered services on this bill.
     Six zeroes indicate provider
     claimed conditional Medicare payment.
13 = Amount is that portion of higher
     priority EGHP insurance payment made on
     behalf of ESRD bene provider
     applied to Medicare covered services
     on this bill. Six zeroes indicate
     the provider claimed conditional
     Medicare payment.
14 = That portion of payment from higher
     priority no fault auto/other
     liability insurance made on behalf of bene
     provider applied to Medicare covered
     services on this bill. Six zeroes indicate
     provider claimed conditional payment

```
                    15 = That portion of a payment from a
                         higher priority WC plan made on behalf
                         of a bene that the provider applied to
                         Medicare covered services on this bill. Six
                         zeroes indicate the provider claimed
                         conditional Medicare payment.
                    16 = That portion of a payment from
                         higher priority PHS or other federal
                         agency made on behalf of a
                         bene the provider applied
                         to Medicare covered services on this
                         bill. Six zeroes indicate
                         provider claimed conditional Medicare
                         payment.
                    17 = Operating Outlier amount - Providers do
                         not report this.  For payer internal use
                         only.  Indicates the amount of day or
                         cost outlier payment to be made.
                         (Do not include any PPS capital outlier
                         payment in this entry).
                    18 = Operating Disproportionate share amount -
                         Providers do not report this.  For
                         payer internal use only.  Indicates the
                         disproportionate share amount applicable
                         to the bill.  Use the amount provided by
                         the disproportionate share field in PRICER.
                         (Do not include any PPS capital DSH adjust-
                         ment in this entry).
                    19 = Operating Indirect medical education amount -
                         Providers do not report this.  For
                         payer internal use only.  Indicates the
                         indirect medical education amount applicable
                         to the bill.  (Do not include PPS capital
                         IME adjustment in this entry).
                    20 = Total payment sent provider for capital
                         under PPS, including HSP, FSP, outlier,
                         old capital, DSH adjustment, IME
                         adjustment, and any exception amount.
                         (used 10/1/91 - 3/1/92 for provider
                         reporting.  Payer only code eff 9/93.)
                    21 = Catastrophic - Medicaid - Eligibility
                         requirements to be determined at state
                         level.  (Medicaid specific/deleted 9/93)
                    22 = Surplus - Medicaid - Eligibility
                         requirements to be determined at state
                         level. (Medicaid specific/deleted 9/93)
                    23 = Recurring monthly income - Medicaid -
                         Eligibility requirements to be
                         determined at state level. (Medicaid
                         specific/deleted 9/93)
                    24 = Medicaid rate code - Medicaid -
                         Eligibility requirements to be
                         determined at state level. (Medicaid
                         specific/deleted 9/93)
                    31 = Patient liability amount - Amount
```

```
                              shown is that which you or the PRO
                              approved to charge the bene for
                              noncovered accommodations, diagnostic
                              procedures or treatments.
                        37 =  Pints of blood furnished - Total
                              number of pints of whole blood or units
  1      CLM_VAL_TB                          Claim Value Table
         ----------                          -----------------

                              of packed red cells furnished to the
                              patient. (eff 10/93)
                        38 =  Blood deductible pints - The number
                              of unreplaced pints of whole blood or
                              units of packed red cells furnished for
                              which the patient is responsible.
                              (eff 10/93)
                        39 =  Pints of blood replaced - The total
                              number of pints of whole blood or units
                              of packed red cells furnished to the
                              patient that have been replaced by or
                              on behalf of the patient. (eff 10/93)
                        40 =  New coverage not implemented by HMO -
                              amount shown is for inpatient charges
                              covered by HMO (eff 3/92).
                              (use this code when the bill includes
                              inpatient charges for newly covered
                              services which are not paid by HMO.)
                        41 =  Amount is that portion of
                              a payment from higher priority BL
                              program made on behalf of
                              bene the provider applied
                              to Medicare covered services on this
                              bill. Six zeroes indicate the
                              provider claimed conditional Medicare
                              payment.
                        42 =  Amount is that portion of a payment
                              from higher priority VA made on behalf
                              of bene the provider applied
                              to Medicare covered services on this
                              bill. Six zeroes indicate the
                              provider claimed conditional Medicare
                              payment.
                        43 =  Disabled bene under age 65 with
                              LGHP - Amount is that portion of
                              a payment from a higher priority LGHP
                              made on behalf of a disabled Medicare
                              bene the provider applied to
                              Medicare covered services on this bill.
                        44 =  Amount provider agreed to accept from
                              primary payer when amount less than charges
                              but more than payment received -
                              When a lesser amount is received and the
                              received amount is less than charges, a
                              Medicare secondary payment is due.
                        46 =  Number of grace days - Following the
                              date of the PRO/UR determination, this
                              is the number of days determined by the
                              PRO/UR to be necessary to arrange for
```

```
                                   the patient's post-discharge care.
                                   (eff 10/93)
                           47 = Any liability insurance - Amount
                                   is that portion from a higher priority
                                   liability insurance made on behalf of
                                   Medicare bene the provider
                                   is applying to Medicare covered
                                   services on this bill. (Eff 9/93)
                           48 = Hemoglobin reading - The latest
   1        CLM_VAL_TB                             Claim Value Table
            ----------                             -----------------


                                   hemoglobin reading taken during this
                                   billing cycle.
                           49 = Latest hematocrit reading taken
                                   during billing cycle - Usually
                                   reported in two pos. (a percentage) to
                                   left of the dollar/cent delimiter.
                                   if provided with a
                                   a decimal, use the 3rd pos. to right
                                   of the delimiter for the third digit.
                           50 = Physical therapy visits - Indicates
                                   the number of physical therapy
                                   visits from onset (at billing provider)
                                   through this billing period.
                           51 = Occupational therapy visits - Indicates
                                   the number of occupational therapy
                                   visits from onset (at the billing
                                   provider) through this billing period.
                           52 = Speech therapy visits - Indicates
                                   the number of speech therapy
                                   visits from onset (at billing provider)
                                   through this billing period.
                           53 = Cardiac rehabilitation - Indicates
                                   the number of cardiac rehabilitation
                                   visits from onset (at billing
                                   provider) through this billing period.
                           54 = Reserved for national assignment.
                           55 = Reserved for national assignment.
                           56 = Hours skilled nursing provided - The
                                   number of hours skilled nursing
                                   provided during the billing period.  Count
                                   only hours spent in the home.
                           57 = Home health visit hours - The number
                                   of home health aide services provided
                                   during the billing period.  Count only
                                   the hours spent in the home.
                           58 = Arterial blood gas - Arterial blood
                                   gas value at beginning of each reporting
                                   period for oxygen therapy. This
                                   value or value 59 will be required on
                                   the initial bill for oxygen therapy and
                                   on the fourth month's bill.
                           59 = Oxygen saturation - Oxygen saturation
                                   at the beginning of each reporting
                                   period for oxygen therapy.  This value or
                                   value 58 will be required on the
                                   initial bill for oxygen therapy and on
```

```
                    the fourth month's bill.
               60 = HHA branch MSA - MSA in which HHA
                    branch is located.
               61 = Location of HHA service or hospice
                    service - the balanced budget act
                    (BBA) requires that the geographic
                    location of where the service was
                    provided be furnished instead of the
                    geographic location of the provider.
                    (eff. 10/1/97)
               62 = Number of Part A home health visits
                    accrued during a period of continuous
1        CLM_VAL_TB                              Claim Value Table
         ----------                              -----------------

                    care - necessitated by the change in
                    payment basis under HH PPS (eff. 10/00)
               63 = Number of Part B home health visits
                    accrued during a period of continuous
                    care - necessitated by the change in
                    payment basis under HH PPS (eff. 10/00)
               64 = Amount of home health payments attributed
                    to the Part A trust fund in a period
                    of continuous care - necessitated by the
                    change in payment basis under HH PPS
                    (eff. 10/00)
               65 = Amount of home health payments attributed
                    to the Part B trust fund in a period
                    of continuous care - necessitated by the
                    change in payment basis under HH PPS
                    (eff. 10/00)
               66 = Reserved for national assignment.
               67 = Peritoneal dialysis - The number of
                    hours of peritoneal dialysis provided
                    during the billing period (only the
                    hours spent in the home).
                    (eff. 10/97)
               68 = EPO drug - Number of units of EPO
                    administered relating to the billing
                    period.
               69 = Reserved for national assignment
               70 = Interest amount - (Providers do not
                    report this.)  Report the amount
                    applied to this bill.
               71 = Funding of ESRD networks - (Providers
                    do not report this.)  Report the
                    amount the Medicare payment was
                    reduced to help fund the ESRD networks.
               72 = Flat rate surgery charge - Code
                    indicates the amount of the charge for
                    outpatient surgery where the hospital
                    has such a charging structure.
               73 = Drug deductible - (For internal use by
                    third party payers only).  Report the
                    amount of the drug deductible to be
                    applied to the claim.
               74 = Drug coinsurance - (For internal use
                    by third party payers only).  Report
```

```
                          the amount of drug coinsurance to be
                          applied to the claim.
                    75 = Gramm/Rudman/Hollings - (Providers do
                          not report this.)  Report the amount of
                          the sequestration applied to this bill.
                    76 = Report provider's percentage of
                          billed charges interim rate during
                          billing period.  Applies to OP
                          hospital, SNF and HHA claims
                          where interim rate is applicable.
                          Report to left of dollar/cents delimiter.
                          (TP payers internal use only)
                    77 = Payer code - This codes is set
                          aside for payer use only.  Providers
                          do not report these codes.
1        CLM_VAL_TB                               Claim Value Table
         ----------                               -----------------

                    78 = Payer code - This codes is set
                          aside for payer use only.  Providers
                          do not report these codes.
                    79 = Payer code - This code is set
                          aside for payer use only.  Providers
                          do not report these codes.
                    80 - 99 = Reserved for state assignment.
                    A1 = Deductible Payer A - The amount
                          assumed by the provider to be applied
                          to the patient's deductible amount
                          involving the indicated payer. (eff 10/93)
                          - Prior value 07
                    A2 = Coinsurance Payer A - The amount assumed
                          by the provider to be applied to the
                          patient's Part B coinsurance amount
                          involving the indicated payer. (eff 10/93)
                    A4 = Self-administered drugs administered in an
                          emergency situation - Ordinarily the only
                          noncovered self-administered drug
                          paid for under Medicare in an emergency
                          situation is insulin administered to a
                          patient in a diabetic coma. (eff 7/97)
                    B1 = Deductible Payer B - The amount
                          assumed by the provider to be applied
                          to the patient's deductible amount
                          involving the indicated payer. (eff 10/93)
                          - Prior value 07
                    B2 = Coinsurance Payer B - the amount assumed
                          by the provider to be applied to the
                          patient's Part B coinsurance amount
                          involving the indicated payer. (eff 10/93)
                    C1 = Deductible Payer C - The amount
                          assumed by the provider to be applied
                          to the patient's deductible amount
                          involving the indicated payer. (eff 10/93)
                          - Prior value 07
                    C2 = Coinsurance Payer C - The amount assumed
                          by the provider to be applied to the
                          patient's Part B coinsurance amount
                          involving the indicated payer. (eff 10/93)
```

```
             Y1 = Part A demo payment - Portion of the
                  payment designated as reimbursement for
                  Part A services per the ORD contract.  No
                  deductible or coinsurance has been
                  applied.  (eff. 5/97)
             Y2 = Part B demo payment - Portion of the
                  payment designated as reimbursement for
                  Part B services for the ORD contract.
                  No deductible or coinsurance has been
                  applied.  (eff. 5/97)
             Y3 = Part B coinsurance - Amount of Part B
                  coinsurance applied by the intermediary
                  to this demo claim.   (eff. 5/97)
             Y4 = Conventional provider Part A payment -
                  Amount Medicare would have reimbursed
                  the provider for Part A services if
                  there had been no demo.  (eff. 5/97)


 1  CTGRY_EQTBL_BENE_IDENT_TB       Category Equatable Beneficiary Identification Code (BIC) Table
    ------------------------        -------------------------------------------------------------


             NCH BIC            SSA Categories
             -------            --------------

             A  = A;J1;J2;J3;J4;M;M1;T;TA
             B  = B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6;
                  TB(F);TD(F);TE(F);TW(F)
             B1 = B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M)
                  TD(M);TE(M);TW(M)
             B3 = B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2
                  W7;TG(F);TL(F);TR(F);TX(F)
             B4 = B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG(M)
                  TL(M);TR(M);TX(M)
             B8 = B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4
                  W8;TH(F);TM(F);TS(F);TY(F)
             BA = BA;BK;BP;DD;DL;DW;E8;EC;KD;KE;KF;KG;W9
                  WC;TJ(F);TN(F);TT(F);TZ(F)
             BD = BD;BL;BQ;DG;DN;DY;EA;ED;KH;KJ;KL;KM;WF
                  WJ;TK(F);TP(F);TU(F);TV(F)
             BG = BG;DH;DQ;DS;EF;EJ;W5;TH(M);TM(M);TS(M)
                  TY(M)
             BH = BH;DJ;DR;DX;EG;EK;WB;TJ(M);TN(M);TT(M)
                  TZ(M)
             BJ = BJ;DK;DT;DZ;EH;EM;WG;TK(M);TP(M);TU(M)
                  TV(M)
             C1 = C1;TC
             C2 = C2;T2
             C3 = C3;T3
             C4 = C4;T4
             C5 = C5;T5
             C6 = C6;T6
             C7 = C7;T7
             C8 = C8;T8
             C9 = C9;T9
             F1 = F1;TF
             F2 = F2;TQ
             F3-F8 = Equatable only to itself (e.g., F3 IS
```

```
                 equatable to F3)
     CA-CZ = Equatable only to itself.  (e.g., CA is
               only equatable to CA)


               ---------------------------------------
                             RRB Categories

     10 = 10
     11 = 11
     13 = 13;17
     14 = 14;16
     15 = 15
     43 = 43
     45 = 45
     46 = 46
     80 = 80
     83 = 83
     84 = 84;86
     85 = 85
```

1 DMERC_LINE_SCRN_RSLT_IND_TB   DMERC Line Screen Result Indicator Table
  --------------------------   --

```
          A = Denied for lack of medical necessity;
              highest level of review was automated
              level I review
          B = Reduced (partially denied) for lack
              of medical necessity; highest level
              of review was automated level I review
          C = Denied as statutorily noncovered;
              highest level of review was automated
              level I review
          D = Reserved for future use
          E = Paid after automated level I review
          F = Denied for lack of medical necessity;
              highest level of review was manual
              level I review
          G = Reduced (partially denied) for lack
              of medical necessity; highest level
              of review was manual level I review
          H = Denied as statutorily noncovered;
              highest level of review was manual
              level I review
          I = Denied for coding/unbundling reasons;
              highest level of review was manual
              level I review
          J = Paid after manual level I review
          K = Denied for lack of medical necessity;
              highest level of review was manual
              level II review
          L = Reduced (partially denied) for lack
              of medical necessity; highest level
              of review was manual level II review
          M = Denied as statutorily noncovered;
              highest level of review was manual
              level II review
          N = Denied for coding/unbundling reasons;
```

```
                            highest level of review was manual
                            level II review
               O = Paid after manual level II review
               P = Denied for lack of medical necessity;
                            highest level of review was manual
                            level III review
               Q = Reduced (partially denied) for lack
                            of medical necessity; highest level
                            of review was manual level III review
               R = Denied as statutorily noncovered;
                            highest level of review was manual
                            level III review
               S = Denied for coding/unbundling reasons;
                            highest level of review was manual
                            level III review
               T = Paid after manual level III review


1    DMERC_LINE_SUPLR_TYPE_TB                    DMERC Line Supplier Type Table
     -----------------------                     ------------------------------


               0 = Clinics, groups, associations,
                            partnerships, or other entities
                            for whom the carrier's own ID number
                            has been assigned.
               1 = Physicians or suppliers billing as
                            solo practitioners for whom SSN's are
                            shown in the physician ID code field.
               2 = Physicians or suppliers billing as
                            solo practitioners for whom the carrier's
                            own physician ID code is shown.
               3 = Suppliers (other than sole proprietorship)
                            for whom EI numbers are used in coding the
                            ID field.
               4 = Suppliers (other than sole proprietorship)
                            for whom the carrier's own code has been
                            shown.
               5 = Institutional providers and
                            independent laboratories for whom EI
                            numbers are used in coding the ID field.
               6 = Institutional providers and
                            independent laboratories for whom the
                            carrier's own ID number is shown.
               7 = Clinics, groups, associations, or
                            partnerships for whom EI numbers
                            are used in coding the ID field.
               8 = Other entities for whom EI numbers
                            are used in coding the ID field or
                            proprietorship for whom EI numbers are
                            used in coding the ID field.


1    DRG_OUTLIER_STAY_TB              Diagnosis Related Group Outlier Patient Stay Table
     -------------------              --------------------------------------------------


               0 = No outlier
               1 = Day outlier (condition code 60)
               2 = Cost outlier, (condition code 61)
```

```
                         *** Non-PPS Only ***

              6 = Valid diagnosis related groups (DRG)
                  received from the intermediary
              7 = HCFA developed DRG
              8 = HCFA developed DRG using patient status
                  code
              9 = Not groupable

1       FI_CLM_ACTN_TB                    Fiscal Intermediary Claim Action Table
        --------------                    --------------------------------------


              1 = Original debit action (includes non-
                  adjustment RTI correction items) - it
                  will always be a 1 in regular bills.
              2 = Cancel by credit adjustment - used
                  only in credit/debit pairs (under HHPPS,
                  updates the RAP).
              3 = Secondary debit adjustment - used only
                  in credit/debit pairs (under HHPPS, would
                  be the final claim or an adjustment on
                  a LUPA).
              4 = Cancel only adjustment (under HHPPS,
                  RAP/final claim/LUPA).
              5 = Force action code 3
              6 = Force action code 2
              8 = Benefits refused (for inpatient bills,
                  an 'R' nonpayment code must also be
                  present
              9 = Payment requested (used on bills that
                  replace previously-submitted benefits-
                  refused bills, action code 8.  In such
                  cases a debit/credit pair is not re-
                  quired.  For inpatient bills, a 'P'
                  should be entered in the nonpayment
                  code.)

1       FI_NUM_TB                         Fiscal Intermediary Number Table
        ---------                         --------------------------------


              00010 = Alabama BC
              00020 = Arkansas BC
              00030 = Arizona BC
              00040 = California BC (term. 12/00)
              00050 = New Mexico BC/CO
              00060 = Connecticut BC
              00070 = Delaware BC - terminated 2/98
              00080 = Florida BC
              00090 = Florida BC
              00101 = Georgia BC
              00121 = Illinois - HCSC
              00123 = Michigan - HCSC
              00130 = Indiana BC/Administar Federal
              00131 = Illinois - Administar
              00140 = Iowa - Wellmark (term. 6/2000)
```

```
                          00150 = Kansas BC
                          00160 = Kentucky/Administar
                          00180 = Maine BC
                          00181 = Maine BC - Massachusetts
                          00190 = Maryland BC
                          00200 = Massachusetts BC - terminated 7/97
                          00210 = Michigan BC - terminated 9/94
                          00220 = Minnesota BC
                          00230 = Mississippi BC
                          00231 = Mississippi BC/LA
                          00232 = Mississippi BC
                          00241 = Missouri BC - terminated 9/92
                          00250 = Montana BC
                          00260 = Nebraska BC
                          00270 = New Hampshire/VT BC
                          00280 = New Jersey BC (term. 8/2000)
                          00290 = New Mexico BC - terminated 11/95
                          00308 = Empire BC
                          00310 = North Carolina BC
                          00320 = North Dakota BC
                          00332 = Community Mutual Ins Co; Ohio-Administar
                          00340 = Oklahoma BC
                          00350 = Oregon BC
                          00351 = Oregon BC/ID.
                          00355 = Oregon-CWF
                          00362 = Independence BC - terminated 8/97
                          00363 = Veritus, Inc (PITTS)
                          00370 = Rhode Island BC
                          00380 = South Carolina BC
                          00390 = Tennessee BC
                          00400 = Texas BC
                          00410 = Utah BC
                          00423 = Virginia BC; Trigon
                          00430 = Washington/Alaska BC
                          00450 = Wisconsin BC
                          00452 = Michigan - Wisconsin BC
                          00454 = United Government Services -
                                  Wisconsin BC (eff. 12/00)
                          00460 = Wyoming BC
                          00468 = N Carolina BC/CPRTIVA
                          00993 = BC/BS Assoc.
                          17120 = Hawaii Medical Service
1         FI_NUM_TB                    Fiscal Intermediary Number Table
          ---------                    --------------------------------


                          50333 = Travelers; Connecticut United Healthcare
                                  (terminated - date unknown)
                          51051 = Aetna California - terminated 6/97
                          51070 = Aetna Connecticut - terminated 6/97
                          51100 = Aetna Florida - terminated 6/97
                          51140 = Aetna Illinois - terminated 6/97
                          51390 = Aetna Pennsylvania - terminated 6/97
                          52280 = Mutual of Omaha
                          57400 = Cooperative, San Juan, PR
                          61000 = Aetna


1    FI_RQST_CLM_CNCL_RSN_TB                    Claim Cancel Reason Code Table
     ----------------------                     ------------------------------
```

```
                    C = Coverage Transfer
                    D = Duplicate Billing
                    H = Other or blank
                    L = Combining two beneficiary master records
                    P = Plan Transfer
                    S = Scramble
                    ************For Action Code 4 ******************
                    *********Effective with HHPPS - 10/00***********
                    A = RAP/Final claim/LUPA is cancelled by Interme-
                        diary.  Does not delete episode.  Do not set
                        cancellation indicator.
                    B = RAP/Final claim/LUPA is cancelled by Interme-
                        diary.  Does not delete episode.  Set
                        cancellation indicator to 1.
                    E = RAP/Final claim/LUPA is cancelled by Interme-
                        diary.  Remove episode.
                    F = RAP/Final claim/LUPA is cancelled by Provider.
                        Remove episode.

1     GEO_SSA_STATE_TB                          State Table
      ----------------                          -----------


                    01 = Alabama
                    02 = Alaska
                    03 = Arizona
                    04 = Arkansas
                    05 = California
                    06 = Colorado
                    07 = Connecticut
                    08 = Delaware
                    09 = District of Columbia
                    10 = Florida
                    11 = Georgia
                    12 = Hawaii
                    13 = Idaho
                    14 = Illinois
                    15 = Indiana
                    16 = Iowa
                    17 = Kansas
                    18 = Kentucky
                    19 = Louisiana
                    20 = Maine
                    21 = Maryland
                    22 = Massachusetts
                    23 = Michigan
                    24 = Minnesota
                    25 = Mississippi
                    26 = Missouri
                    27 = Montana
                    28 = Nebraska
                    29 = Nevada
                    30 = New Hampshire
                    31 = New Jersey
                    32 = New Mexico
                    33 = New York
```

```
                                34 = North Carolina
                                35 = North Dakota
                                36 = Ohio
                                37 = Oklahoma
                                38 = Oregon
                                39 = Pennsylvania
                                40 = Puerto Rico
                                41 = Rhode Island
                                42 = South Carolina
                                43 = South Dakota
                                44 = Tennessee
                                45 = Texas
                                46 = Utah
                                47 = Vermont
                                48 = Virgin Islands
                                49 = Virginia
                                50 = Washington
                                51 = West Virginia
                                52 = Wisconsin
                                53 = Wyoming
                                54 = Africa
                                55 = Asia
                                56 = Canada & Islands
                                57 = Central America and West Indies
1     GEO_SSA_STATE_TB                           State Table
      ----------------                           -----------

                                58 = Europe
                                59 = Mexico
                                60 = Oceania
                                61 = Philippines
                                62 = South America
                                63 = U.S. Possessions
                                64 = American Samoa
                                65 = Guam
                                66 = Saipan
                                97 = Northern Marianas
                                98 = Guam
                                99 = With 000 county code is American Samoa;
                                     otherwise unknown


1     HCFA_PRVDR_SPCLTY_TB                  HCFA Provider Specialty Table
      --------------------                  -----------------------------


                                    **Prior to 5/92**

                                01 = General practice
                                02 = General surgery
                                03 = Allergy (revised 10/91 to mean allergy/
                                     immunology)
                                04 = Otology, laryngology, rhinology
                                     revised 10/91 to mean otolaryngology)
                                05 = Anesthesiology
                                06 = Cardiovascular disease (revised 10/91
                                     to mean cardiology)
                                07 = Dermatology
                                08 = Family practice
```

```
09 = Gynecology--osteopaths only (deleted
     10/91; changed to '16')
10 = Gastroenterology
11 = Internal medicine
12 = Manipulative therapy (osteopaths only)
     (revised 10/91 to mean osteopathic
     manipulative therapy)
13 = Neurology
14 = Neurological surgery (revised 10/91 to
     mean neurosurgery)
15 = Obstetrics--osteopaths only (deleted
     10/91; changed to '16')
16 = OB-gynecology
17 = Ophthalmology, otology, laryngology
     rhinology--osteopaths only (deleted
     10/91; changed to '18' if physicians
     practice is more than 50% ophthalmology
     or to '04' if physician's practice is
     more than 50% otolaryngology.  If
     practice is 50/50, choose specialty
     with greater allowed charges.
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Pathologic anatomy, clinical pathology-
     osteopaths only (deleted 10/91;
     changed to '22')
22 = Pathology
23 = Peripheral vascular disease or surgery
     (deleted 10/91; changed to '76')
24 = Plastic surgery (revised to mean
     plastic and reconstructive surgery).
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Psychiatry, neurology (osteopaths only)
     (deleted 10/91; changed to '86')
28 = Proctology (revised 10/91 to mean
     colorectal surgery).
29 = Pulmonary disease
30 = Radiology (revised 10/91 to mean
     diagnostic radiology)
31 = Roentgenology, radiology (osteopaths)
     (deleted 10/91; changed to '30')
32 = Radiation therapy--osteopaths (deleted
```

```
     10/91; changed to '92')
33 = Thoracic surgery
34 = Urology
35 = Chiropractor, licensed (revised 10/91
     to mean chiropractic)
36 = Nuclear medicine
37 = Pediatrics (revised 10/91 to mean
     pediatric medicine)
38 = Geriatrics (revised 10/91 to mean
     geriatric medicine)
39 = Nephrology
```

```
40 = Hand surgery
41 = Optometrist - services related to
     condition of aphakia (revised 10/91 to
     mean optometrist)
42 = Certified nurse midwife (added 7/88)
43 = Certified registered nurse anesthetist
     (revised 10/91 to mean CRNA,
     anesthesia assistant)
44 = Infectious disease
46 = Endocrinology (added 10/91)
48 = Podiatry - surgery chiropody (revised
     10/91 to mean podiatry)
49 = Miscellaneous (include ASCS)
51 = Medical supply company with C.O.
     certification (certified orthotist -
     certified by American Board for
     Certification in Prosthetics and
     Orthotics.
52 = Medical supply company with C.P.
     certification (certified prosthetist -
     certified by American Board for
     Certification in Prosthetics and Orthotics).
53 = Medical supply company with C.P.O.
     certification (certified prosthetist -
     orthotist - certified by American
     Board for Certification in Prosthetics
     and Orthotics).
54 = Medical supply company not included in
     51, 52, or 53.
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist -
     orthotist
58 = Individuals not included in 55,56 or 57
59 = Ambulance service supplier (e.g.
     private ambulance companies, funeral
     homes, etc.)
60 = Public health or welfare agencies
     (federal, state, and local)
61 = Voluntary health or charitable agencies
     (e.g. National Cancer Society, National
     Heart Association, Catholic Charities)
62 = Psychologist--billing independently
63 = Portable X-ray supplier--billing
     independently (revised 10/91 to mean
     portable X-ray supplier)
64 = Audiologist (billing independently)
```

1	HCFA_PRVDR_SPCLTY_TB	HCFA Provider Specialty Table
	--------------------	--------------------------

```
65 = Physical therapist (independent practice)
66 = Rheumatology (added 10/91)
67 = Occupational therapist--independent
     practice
68 = Clinical psychologist
69 = Independent laboratory--billing
     independently (revised 10/91 to mean
     independent clinical laboratory --
```

```
                    billing independently)
      70 = Clinic or other group practice, except
           Group Practice Prepayment Plan (GPPP)
      71 = Group Practice Prepayment Plan - diagnostic
           X-ray (do not use after 1/92)
      72 = Group Practice Prepayment Plan - diagnostic
           laboratory (do not use after 1/92)
      73 = Group Practice Prepayment Plan -
           physiotherapy (do not use after 1/92)
      74 = Group Practice Prepayment Plan - occupational
           therapy (do not use after 1/92)
      75 = Group Practice Prepayment Plan - other
           medical care (do not use after 1/92)
      76 = Peripheral vascular disease
           (added 10/91)
      77 = Vascular surgery (added 10/91)
      78 = Cardiac surgery (added 10/91)
      79 = Addiction medicine (added 10/91)
      8O = Clinical social worker (1991)
      81 = Critical care-intensivists (added 10/91)
      82 = Ophthalmology, cataracts specialty
           (added 10/91; used only until 5/92)
      83 = Hematology/oncology (added 10/91)
      84 = Preventive medicine (added 10/91)
      85 = Maxillofacial surgery (added 10/91)
      86 = Neuropsychiatry (added 10/91)
      87 = All other (e.g. drug and department
           stores) (revised 10/91 to mean all
           other suppliers)
      88 = Unknown (revised 10/91 to mean
           physician assistant)
      90 = Medical oncology (added 10/91)
      91 = Surgical oncology (added 10/91)
      92 = Radiation oncology (added 10/91)
      93 = Emergency medicine (added 10/91)
      94 = Interventional radiology (added 10/91)
      95 = Independent physiological laboratory
           (added 10/91)
      96 = Unknown physician specialty
           (added 10/91)
      99 = Unknown--incl. social worker's
           psychiatric services (revised 10/91 to
           mean unknown supplier/provider)
            ---------------------------------------
                     **Effective 5/92**

      00 = Carrier wide
      01 = General practice
      02 = General surgery
      03 = Allergy/immunology
```

```
      04 = Otolaryngology
      05 = Anesthesiology
      06 = Cardiology
      07 = Dermatology
      08 = Family practice
```

```
09 = Gynecology (osteopaths only)
     (discontinued 5/92 use code 16)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative therapy
13 = Neurology
14 = Neurosurgery
15 = Obstetrics (osteopaths only)
     (discontinued 5/92 use code 16)
16 = Obstetrics/gynecology
17 = Ophthalmology, otology, laryngology,
     rhinology (osteopaths only)
     (discontinued 5/92 use codes 18 or 04
     depending on percentage of practice)
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Pathologic anatomy, clinical
     pathology (osteopaths only)
     (discontinued 5/92 use code 22)
22 = Pathology
23 = Peripheral vascular disease, medical
     or surgical (osteopaths only)
     (discontinued 5/92 use code 76)
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Psychiatry, neurology (osteopaths
     only) (discontinued 5/92 use code 86)
28 = Colorectal surgery (formerly
     proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Roentgenology, radiology (osteopaths
     only) (discontinued 5/92 use code 30)
32 = Radiation therapy (osteopaths only)
     (discontinued 5/92 use code 92)
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry (revised 10/93 to
     mean optometrist)
42 = Certified nurse midwife (eff 1/87)
43 = Crna, anesthesia assistant
     (eff 1/87)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology (eff 5/92)
```

```
47 = Independent Diagnostic Testing Facility
     (IDTF) (eff. 6/98)
```

```
48 = Podiatry
49 = Ambulatory surgical center
     (formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with
     certified orthotist (certified by
     American Board for Certification in
     Prosthetics And Orthotics)
52 = Medical supply company with
     certified prosthetist
     (certified by American Board for
     Certification In Prosthetics And
     Orthotics)
53 = Medical supply company with
     certified prosthetist-orthotist
     (certified by American Board for
     Certification in Prosthetics
     and Orthotics)
54 = Medical supply company not included
     in 51, 52, or 53.  (Revised 10/93
     to mean medical supply company for DMERC)
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist-
     orthotist
58 = Individuals not included in 55, 56,
     or 57 (revised 10/93  to mean medical
     supply company with registered
     pharmacist)
59 = Ambulance service supplier, e.G.,
     private ambulance companies, funeral
     homes, etc.
60 = Public health or welfare agencies
     (federal, state, and local)
61 = Voluntary health or charitable
     agencies (e.G., National Cancer
     Society, National Heart Associiation,
     Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier
64 = Audiologist (billing independently)
65 = Physical therapist (independently
     practicing)
66 = Rheumatology (eff 5/92)
     Note: during 93/94 DMERC also used this
     to mean medical supply company with
     respiratory therapist
67 = Occupational therapist (independently
     practicing)
68 = Clinical psychologist
69 = Clinical laboratory (billing
     independently)
70 = Multispecialty clinic or group
     practice
71 = Diagnostic X-ray (GPPP) (not to
     be assigned after 5/92)
```

```
72 = Diagnostic laboratory (GPPP)
     (not to be assigned after 5/92)
73 = Physiotherapy (GPPP) (not to be
     assigned after 5/92)
74 = Occupational therapy (GPPP)
     (not to be assigned after 5/92)
75 = Other medical care (GPPP) (not to
     assigned after 5/92)
76 = Peripheral vascular disease
     (eff 5/92)
77 = Vascular surgery (eff 5/92)
78 = Cardiac surgery (eff 5/92)
79 = Addiction medicine (eff 5/92)
80 = Licensed clinical social worker
81 = Critical care (intensivists)
     (eff 5/92)
82 = Hematology (eff 5/92)
83 = Hematology/oncology (eff 5/92)
84 = Preventive medicine (eff 5/92)
85 = Maxillofacial surgery (eff 5/92)
86 = Neuropsychiatry (eff 5/92)
87 = All other suppliers (e.g. drug and
     department stores) (note: DMERC used
     87 to mean department store from 10/93
     through 9/94; recoded eff 10/94 to A7;
     NCH cross-walked DMERC reported 87 to A7.
88 = Unknown supplier/provider specialty
     (note: DMERC used 87 to mean grocery
     store from 10/93 - 9/94; recoded eff
     10/94 to A8; NCH cross-walked DMERC
     reported 88 to A8.
89 = Certified clinical nurse specialist
90 = Medical oncology (eff 5/92)
91 = Surgical oncology (eff 5/92)
92 = Radiation oncology (eff 5/92)
93 = Emergency medicine (eff 5/92)
94 = Interventional radiology (eff 5/92)
95 = Independent physiological
     laboratory (eff 5/92)
96 = Optician (eff 10/93)
97 = Physician assistant (eff 5/92)
98 = Gynecologist/oncologist (eff 10/94)
99 = Unknown physician specialty
A0 = Hospital (eff 10/93) (DMERCs only)
A1 = SNF (eff 10/93) (DMERCs only)
A2 = Intermediate care nursing facility
     (eff 10/93) (DMERCs only)
A3 = Nursing facility, other (eff 10/93)
     (DMERCs only)
A4 = HHA (eff 10/93) (DMERCs only)
A5 = Pharmacy (eff 10/93) (DMERCs only)
A6 = Medical supply company with respiratory
     therapist (eff 10/93) (DMERCs only)
A7 = Department store (for DMERC use:
     eff 10/94, but cross-walked from
     code 87 eff 10/93)
A8 = Grocery store (for DMERC use:
```

```
1    HCFA_PRVDR_SPCLTY_TB                eff 10/94, but cross-walked from
     -------------------                HCFA Provider Specialty Table
                                        ----------------------------

                                   code 88 eff 10/93)


1    HCFA_TYPE_SRVC_TB                   HCFA Type of Service Table
     -----------------                  --------------------------


              1 = Medical care
              2 = Surgery
              3 = Consultation
              4 = Diagnostic radiology
              5 = Diagnostic laboratory
              6 = Therapeutic radiology
              7 = Anesthesia
              8 = Assistant at surgery
              9 = Other medical items or services
              0 = Whole blood only eff 01/96,
                  whole blood or packed red cells before 01/96
              A = Used durable medical equipment (DME)
              B = High risk screening mammography
                  (obsolete 1/1/98)
              C = Low risk screening mammography
                  (obsolete 1/1/98)
              D = Ambulance (eff 04/95)
              E = Enteral/parenteral nutrients/supplies
                  (eff 04/95)
              F = Ambulatory surgical center (facility
                  usage for surgical services)
              G = Immunosuppressive drugs
              H = Hospice services (discontinued 01/95)
              I = Purchase of DME (installment basis)
                  (discontinued 04/95)
              J = Diabetic shoes (eff 04/95)
              K = Hearing items and services (eff 04/95)
              L = ESRD supplies (eff 04/95)
                  (renal supplier in the home before 04/95)
              M = Monthly capitation payment for dialysis
              N = Kidney donor
              P = Lump sum purchase of DME, prosthetics,
                  orthotics
              Q = Vision items or services
              R = Rental of DME
              S = Surgical dressings or other medical supplies
                  (eff 04/95)
              T = Psychological therapy (term. 12/31/97)
                  outpatient mental health limitation (eff. 1/1/98)
              U = Occupational therapy
              V = Pneumococcal/flu vaccine (eff 01/96),
                  Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),
                  Pneumococcal only before 04/95
              W = Physical therapy
              Y = Second opinion on elective surgery
                  (obsoleted 1/97)
              Z = Third opinion on elective surgery
                  (obsoleted 1/97)
```

```
1 LINE_ADDTNL_CLM_DCMTN_IND_TB          Line Additional Claim Documentation Indicator Table
  --------------------------            ---------------------------------------------------


                              0 = No additional documentation
                              1 = Additional documentation submitted for
                                  non-DME EMC claim
                              2 = CMN/prescription/other documentation submitted
                                  which justifies medical necessity
                              3 = Prior authorization obtained and approved
                              4 = Prior authorization requested but not approved
                              5 = CMN/prescription/other documentation submitted
                                  but did not justify medical necessity
                              6 = CMN/prescription/other documentation submitted
                                  and approved after prior authorization rejected
                              7 = Recertification CMN/prescription/other
                                  documentation

1       LINE_PLC_SRVC_TB                            Line Place Of Service Table
        ----------------                            ---------------------------


                                      **Prior To 1/92**

                              1 = Office
                              2 = Home
                              3 = Inpatient hospital
                              4 = SNF
                              5 = Outpatient hospital
                              6 = Independent lab
                              7 = Other
                              8 = Independent kidney disease treatment
                                  center
                              9 = Ambulatory
                              A = Ambulance service
                              H = Hospice
                              M = Mental health, rural mental health
                              N = Nursing home
                              R = Rural codes

                              ---------------------------------------
                                      **Effective 1/92**

                              11 = Office
                              12 = Home
                              21 = Inpatient hospital
                              22 = Outpatient hospital
                              23 = Emergency room - hospital
                              24 = Ambulatory surgical center
                              25 = Birthing center
                              26 = Military treatment facility
                              31 = Skilled nursing facility
                              32 = Nursing facility
                              33 = Custodial care facility
                              34 = Hospice
                              35 = Adult living care facilities (ALCF)
                                   (eff. NYD - added 12/3/97)
```

```
                                   41 = Ambulance - land
                                   42 = Ambulance - air or water
                                   50 = Federally qualified health centers
                                        (eff. 10/1/93)
                                   51 = Inpatient psychiatric facility
                                   52 = Psychiatric facility partial hospitalization
                                   53 = Community mental health center
                                   54 = Intermediate care facility/mentally
                                        retarded
                                   55 = Residential substance abuse treatment
                                        facility
                                   56 = Psychiatric residential treatment
                                        center
                                   60 = Mass immunizations center (eff. 9/1/97)
                                   61 = Comprehensive inpatient rehabilitation
                                        facility
                                   62 = Comprehensive outpatient rehabilitation
                                        facility
                                   65 = End stage renal disease treatment facility
                                   71 = State or local public health clinic
                                   72 = Rural health clinic
                                   81 = Independent laboratory
1      LINE_PLC_SRVC_TB                            Line Place Of Service Table
       ----------------                            ---------------------------

                                   99 = Other unlisted facility


1      LINE_PMT_IND_TB                             Line Payment Indicator Table
       ---------------                             ----------------------------



                                   1 = Actual charge
                                   2 = Customary charge
                                   3 = Prevailing charge (adjusted, unadjusted
                                       gap fill, etc)
                                   4 = Other (ASC fees, radiology and
                                       outpatient limits, and non-payment
                                       because of denial.
                                   5 = Lab fee schedule
                                   6 = Physician fee schedule - full fee
                                       schedule amount
                                   7 = Physician fee schedule - transition
                                   8 = Clinical psychologist fee schedule
                                   9 = DME and prosthetics/orthotics fee
                                       schedules (eff. 4/97)

1      LINE_PRCSG_IND_TB                           Line Processing Indicator Table
       -----------------                           -------------------------------



                                   A = Allowed
                                   B = Benefits exhausted
                                   C = Noncovered care
                                   D = Denied (existed prior to 1991; from
                                       BMAD)
                                   I = Invalid data
                                   L = CLIA (eff 9/92)
                                   M = Multiple submittal--duplicate line item
```

```
                              N = Medically unnecessary
                              O = Other
                              P = Physician ownership denial (eff 3/92)
                              Q = MSP cost avoided (contractor #88888) -
                                  voluntary agreement (eff. 1/98)
                              R = Reprocessed--adjustments based on
                                  subsequent reprocessing of claim
                              S = Secondary payer
                              T = MSP cost avoided - IEQ contractor
                                  (eff. 7/76)
                              U = MSP cost avoided - HMO rate cell
                                  adjustment (eff. 7/96)
                              V = MSP cost avoided - litigation
                                  settlement (eff. 7/96)
                              X = MSP cost avoided - generic
                              Y = MSP cost avoided - IRS/SSA data
                                  match project
                              Z = Bundled test, no payment
                                  (eff. 1/1/98)


1  LINE_PRVDR_PRTCPTG_IND_TB              Line Provider Participating Indicator Table
   ------------------------              -------------------------------------------


                              1 = Participating
                              2 = All or some covered and allowed
                                  expenses applied to deductible Participating
                              3 = Assignment accepted/non-participating
                              4 = Assignment not accepted/non-participating
                              5 = Assignment accepted but all or some
                                  covered and allowed expenses applied
                                  to deductible Non-participating.
                              6 = Assignment not accepted and all covered
                                  and allowed expenses applied to deductible
                                  non-participating.
                              7 = Participating provider not accepting
                                  assignment.


1     NCH_CLM_TYPE_TB                          NCH Claim Type Table
      ---------------                          --------------------


                              10 = HHA claim
                              20 = Non swing bed SNF claim
                              30 = Swing bed SNF claim
                              40 = Outpatient claim
                              41 = Outpatient 'Full-Encounter' claim
                                   (available in NMUD)
                              42 = Outpatient 'Abbreviated-Encounter' claim
                                   (available in NMUD)
                              50 = Hospice claim
                              60 = Inpatient claim
                              61 = Inpatient 'Full-Encounter' claim
                              62 = Inpatient 'Abbreviated-Encounter claim
                                   (available in NMUD)
                              71 = RIC O local carrier non-DMEPOS claim
                              72 = RIC O local carrier DMEPOS claim
                              73 = Physician 'Full-Encounter' claim
```

```
                    (available in NMUD)
       81 = RIC M DMERC non-DMEPOS claim
       82 = RIC M DMERC DMEPOS claim


1      NCH_EDIT_TB                              NCH EDIT TABLE
       -----------                              --------------


                    A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE
                    A000 = (C) REIMB > $100,000 OR UNITS > 150
                    A002 = (C) CLAIM IDENTIFIER (CAN)
                    A003 = (C) BENEFICIARY IDENTIFICATION (BIC)
                    A004 = (C) PATIENT SURNAME BLANK
                    A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
                    A006 = (C) DATE OF BIRTH IS NOT NUMERIC
                    A007 = (C) INVALID GENDER (0, 1, 2)
                    A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)
                    A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73
                    A1X1 = (C) PERCENT ALLOWED INDICATOR
                    A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589
                    A1X3 = (C) DT>96365,DIAG=V725
                    A1X4 = (C) INVALID DIAGNOSTIC CODES
                    C050 = (U) HOSPICE - SPELL VALUE INVALID
                    D102 = (C) DME DATE OF BIRTH INVALID
                    D2X2 = (C) DME SCREEN SAVINGS INVALID
                    D2X3 = (C) DME SCREEN RESULT INVALID
                    D2X4 = (C) DME DECISION IND INVALID
                    D2X5 = (C) DME WAIVER OF PROV LIAB INVALID
                    D3X1 = (C) DME NATIONAL DRUG CODE INVALID
                    D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID
                    D4X2 = (C) DME OUT OF DMERC SERVICE AREA
                    D4X3 = (C) DME STATE CODE INVALID
                    D5X1 = (C) TOS INVALID FOR DME HCPCS
                    D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING
                    D5X3 = (C) DME INVALID USE OF MS MODIFIER
                    D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED
                    D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS
                    D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID
                    D6X1 = (C) DME SUPPLIER NUMBER MISSING
                    D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
                    D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1
                    D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6
                    XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE
                    Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1
                    Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1
                    Y003 = (C) HCPCS R0075/UNITS=SERVICES
                    Y010 = (C) TOB=13X/14X AND T.C.>$7,500
                    Y011 = (C) INP CLAIM/REIM > $75,000
                    Z001 = (C) RVNU 820-859 REQ COND CODE 71-76
                    Z002 = (C) CC M2 PRESENT/REIMB > $150,000
                    Z003 = (C) CC M2 PRESENT/UNITS > 150
                    Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX
                    Z005 = (C) REIMB>99999 AND REIMB<150000
                    Z006 = (C) UNITS>99 AND UNITS<150
                    Z237 = (E) HOSPICE OVERLAP - DATE ZERO
                    0011 = (C) ACTION CODE INVALID
                    0013 = (C) CABG/PCOE AND INVALID ADMIT DATE
                    0014 = (C) DEMO NUM NOT=01-06,08,15,31
```

```
                         0015 = (C) ESRD PLAN BUT DEMO ID NOT = 15
                         0016 = (C) INVALID VA CLAIM
                         0017 = (C) DEMO=31,TOB<>11 OR SPEC<>08
                         0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5
                         0020 = (C) CANCEL ONLY CODE INVALID
                         0021 = (C) DEMO COUNT > 1
                         0301 = (C) INVALID HI CLAIM NUMBER
1        NCH_EDIT_TB                                    NCH EDIT TABLE
         -----------                                    --------------

                         0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK
                         04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)
                         04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
                         0401 = (C) BILL TYPE/PROVIDER INVALID
                         0402 = (C) BILL TYPE/REV CODE/PROVR RANGE
                         0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092
                         0407 = (C) RESPITE CARE BILL TYPE 34X,NO REV 66
                         0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974
                         0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636
                         0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES
                         0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS
                         0414 = (C) VALU CD 61,MSA AMOUNT MISSING
                         0415 = (C) HOME HEALTH INCORRECT ALPHA RIC
                         05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE
                         05X5 = (C) UPIN REQUIRED FOR DME HCPCS
                         0501 = (C) UNIQUE PHY IDEN. (UPIN) BLANK
                         0502 = (C) UNIQUE PHY IDEN. (UPIN) INVALID
                         0601 = (C) GENDER INVALID
                         0701 = (C) CONTRACTOR INVALID CARRIER/ETC
                         0702 = (C) PROVIDER NUMBER INCONSISTANT
                         0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
                         0704 = (C) INVALID CONT FOR CABG DEMO
                         0705 = (C) INVALID CONT FOR PCOE DEMO
                         0901 = (C) INVALID DISP CODE OF 02
                         0902 = (C) INVALID DISP CODE OF SPACES
                         0903 = (C) INVALID DISP CODE
                         1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE
                         13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE
                         1301 = (C) LINE COUNT NOT NUMERIC OR > 13
                         1302 = (C) RECORD LENGTH INVALID
                         1401 = (C) INVALID MEDICARE STATUS CODE
                         1501 = (C) ADMIT DATE/ENTRY CODE INVALID
                         1502 = (C) ADMIT DATE > STAY FROM DATE
                         1503 = (C) ADMIT DATE INVALID WITH THRU DATE
                         1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE
                         1505 = (C) HCPCS W SERVICE DATES > 09-30-94
                         1601 = (C) INVESTIGATION IND INVALID
                         1701 = (C) SPLIT IND INVALID
                         1801 = (C) PAY-DENY CODE INVALID
                         1802 = (C) HEADER AMT AND NOT DENIED CLAIM
                         1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME
                         1901 = (C) AB CROSSOVER IND INVALID
                         2001 = (C) HOSPICE OVERRIDE INVALID
                         2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID
                         2102 = (C) FROM/THRU DATE OR KRON/PAT STAT
                         2201 = (C) FROM/THRU DATE OR HCPCS YR INVAL
                         2202 = (C) STAY-FROM DATE > THRU-DATE
                         2203 = (C) THRU DATE INVALID
```

```
                    2204 = (C) FROM DATE BEFORE EFFECTIVE DATE
                    2205 = (C) DATE YEARS DIFFERENT ON OUTPAT
                    2207 = (C) MAMMOGRAPHY BEFORE 1991
                    2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID
                    2302 = (C) COVERED DAYS INVALID OR INCONSIST
                    2303 = (C) COST REPORT DAYS > ACCOMIDATION
                    2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL
                    2305 = (C) UTIL DAYS = INCONSISTENCIES
                    2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT
                    2307 = (C) COND=40,UTIL DYS >0/VAL CDE A1,08,09
```

1   NCH_EDIT_TB   NCH EDIT TABLE
         -----------   --------------

```
                    2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO
                    2401 = (C) NON-UTIL DAYS INVALID
                    2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL
                    2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE
                    2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN
                    2504 = (C) COINSURANCE AMOUNT EXCESSIVE
                    2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT
                    2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST
                    2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR
                    2508 = (C) COINSURANCE DAYS INVALID FOR TRAN
                    2601 = (C) CLAIM PAID DT INVALID OR LIFE RES
                    2602 = (C) LR-DYS, NO VAL 08,10/PD/DEN>CUR+27
                    2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
                    2604 = (C) PPS BILL, NO DAY OUTLIER
                    2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
                    28XA = (C) UTIL DAYS > FROM TO BENEF EXH
                    28XB = (C) BENEFITS EXH DATE > FROM DATE
                    28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
                    28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
                    28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
                    28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
                    28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
                    28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
                    28XN = (C) INVALID OCC CODE
                    28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES
                    28X1 = (C) OCCUR DATE INVALID
                    28X2 = (C) OCCUR = 20 AND TRANS = 4
                    28X3 = (C) OCCUR 20 DATE < ADMIT DATE
                    28X4 = (C) OCCUR 20 DATE > ADMIT + 12
                    28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM
                    28X6 = (C) OCCUR 20 DATE < BENE EXH DATE
                    28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
                    28X8 = (C) OCCUR 22 DATE < FROM OR > THRU
                    28X9 = (C) UTIL > FROM - THRU LESS NCOV
                    33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)
                    33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)
                    33X3 = (C) QS DAYS/ADMISSION ARE INVALID
                    33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)
                    33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE
                    33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091
                    33X7 = (C) TOB<>18/21/28/51,COND=WO
                    33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001
                    33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT
                    34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN
                    3401 = (C) DEMO ID = 04 AND RIC NOT = 1
```

```
                    35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS
                    35X2 = (C) COND = 60 OR 61 AND NO VALU 17
                    35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0
                    36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU
                    3701 = (C) ASSIGN CODE INVALID
                    3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA
                    3706 = (C) INVALID IDE NUMBER-NOT IN FILE
                    3710 = (C) NUM OF IDE# > REV 0624
                    3715 = (C) NUM OF IDE# < REV 0624
                    3720 = (C) IDE AND LINE ITEM NUMBER > 2
                    3801 = (C) AMT BENE PD INVALID
                    4001 = (C) BLOOD PINTS FURNISHED INVALID
                    4002 = (C) BLOOD FURNISHED/REPLACED INVALID
1        NCH_EDIT_TB                          NCH EDIT TABLE
         -----------                          --------------

                    4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
                    4201 = (C) BLOOD PINTS UNREPLACED INVALID
                    4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED
                    4203 = (C) INVALID CPO PROVIDER NUMBER
                    4301 = (C) BLOOD DEDUCTABLE INVALID
                    4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
                    4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
                    4304 = (C) BLOOD DEDUCT > 3 - REPLACED
                    4501 = (C) PRIMARY DIAGNOSIS INVALID
                    46XA = (C) MSP VET AND VET AT MEDICARE
                    46XB = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
                    46XC = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
                    46XG = (C) VALU CODE 20 INVALID
                    46XN = (C) VALUE CODE 37,38,39 INVALID
                    46XO = (C) VALUE CDE 38>0/VAL CDE 06 MISSNG
                    46XP = (C) BLD UNREP VS REV CDS AND/OR UNITS
                    46XQ = (C) VALUE CDE 37=39 AND 38 IS PRESENT
                    46XR = (C) BLD FIELDS VS REV CDE 380,381,382
                    46XS = (C) VALU CODE 39, AND 37 IS NOT PRESENT
                    46XT = (C) CABG/PCOE,VC<>Y1,Y2,Y3,Y4,VA NOT>0
                    46X1 = (C) VALUE AMOUNT INVALID
                    46X2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
                    46X3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
                    46X4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
                    46X5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
                    46X6 = (C) VALU 17 AND NO COND CODE 60 OR 61
                    46X7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16
                    46X8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
                    46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN
                    4600 = (C) CAPITAL TOTAL NOT = CAP VALUES
                    4601 = (C) CABG/PCOE, MSP CODE PRESENT
                    4603 = (C) DEMO ID = 03 AND RIC NOT=6,7
                    4901 = (C) PCOE/CABG,DEN CD NOT D
                    4902 = (C) PCOE/CABG BUT DME
                    50X1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85
                    50X2 = (C) REV CD=054X,MOD NOT = QM,QN
                    5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS
                    5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD
                    5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER
                    51XA = (C) HCPCS EYEWARE & REV CODE NOT 274
                    51XC = (C) HCPCS REQUIRES DIAG CODE OF CANCER
                    51XD = (C) HCPCS REQUIRES UNITS > ZERO
```

```
            51XE = (C) HCPCS REQUIRES REVENUE CODE 636
            51XF = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
            51XG = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A
            51XH = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044
            51XI = (C) TOB 21X/P82<>2/3/4:REV CD>8999<9045
            51XJ = (C) TOB 21X/REV CD: SVC-FROM DT INVALID
            51XK = (C) TOB 21X/P82=2/3/4,REV CD = NNX
            51XL = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83
            51XM = (C) 21X,RC>9041/<9045,RC<>4/234
            51XN = (C) 21X,RC>9032/<9042,RC<>4/234
            51XP = (C) HHA RC DATE OF SRVC MISSING
            51XQ = (C) NO RC 0636 OR DTE INVALID
            51XR = (C) DEMO ID=01,RIC NOT=2
            51XS = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21
            51X0 = (C) REV CENTER CODE INVALID
            51X1 = (C) REV CODE CHECK
```

```
            51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE
            51X3 = (C) UNITS MUST BE > 0
            51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR
            51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE
            51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
            51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85
            51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID
            51X9 = (C) HCPCS/REV CODE/BILL TYPE
            5100 = (U) TRANSITION SPELL / SNF
            5160 = (U) LATE CHG HSP BILL STAY DAYS > 0
            5166 = (U) PROVIDER NE TO 1ST WORK PRVDR
            5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT
            5169 = (U) PROVIDER NE TO WORK PROVIDER
            5177 = (U) PROVIDER NE TO WORK PROVIDER
            5178 = (U) HOSPICE BILL THRU < DOLBA
            5181 = (U) HOSP BILL OCCR 27 DISCREPANCY
            5200 = (E) ENTITLEMENT EFFECTIVE DATE
            5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
            5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
            5202 = (U) HOSPICE TRAILER ERROR
            5203 = (E) ENTITLEMENT HOSPICE PERIODS
            5203 = (U) HOSPICE START DATE ERROR
            5204 = (U) HOSPICE DATE DIFFERENCE NE 90
            5205 = (U) HOSPICE DATE DISCREPANCY
            5206 = (U) HOSPICE DATE DISCREPANCY
            5207 = (U) HOSPICE THRU > TERM DATE 2ND
            5208 = (U) HOSPICE PERIOD NUMBER BLANK
            5209 = (U) HOSPICE DATE DISCREPANCY
            5210 = (E) ENTITLEMENT FRM/TRU/END DATES
            5211 = (E) ENTITLEMENT DATE DEATH/THRU
            5212 = (E) ENTITLEMENT DATE DEATH/THRU
            5213 = (E) ENTITLEMENT DATE DEATH MBR
            5220 = (E) ENTITLEMENT FROM/EFF DATES
            5225 = (E) ENT INP PPS SPAN 70 DATES
            5232 = (E) ENTL HMO NO HMO OVERRIDE CDE
            5233 = (E) ENTITLEMENT HMO PERIODS
            5234 = (E) ENTITLEMENT HMO NUMBER NEEDED
            5235 = (E) ENTITLEMENT HMO HOSP+NO CC07
            5236 = (E) ENTITLEMENT HMO HOSP + CC07
```

```
                                 5237 = (E) ENTITLEMENT HOSP OVERLAP
                                 5238 = (U) HOSPICE CLAIM OVERLAP > 90
                                 5239 = (U) HOSPICE CLAIM OVERLAP > 60
                                 524Z = (E) HOSP OVERLAP NO OVD NO DEMO
                                 5240 = (U) HOSPICE DAYS STAY+USED > 90
                                 5241 = (U) HOSPICE DAYS STAY+USED > 60
                                 5242 = (C) INVALID CARRIER FOR RRB
                                 5243 = (C) HMO=90091,INVALID SERVICE DTE
                                 5244 = (E) DEMO CABG/PCOE MISSING ENTL
                                 5245 = (C) INVALID CARRIER FOR NON RRB
                                 525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO
                                 5250 = (U) HOSPICE DOEBA/DOLBA
                                 5255 = (U) HOSPICE DAYS USED
                                 5256 = (U) HOSPICE DAYS USED > 999
                                 526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0
                                 526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0
                                 527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0
                                 527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0
                                 5299 = (U) HOSPICE PERIOD NUMBER ERROR
1        NCH_EDIT_TB                                  NCH EDIT TABLE
         -----------                                  --------------

                                 5320 = (U) BILL > DOEBA AND IND-1 = 2
                                 5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY
                                 5355 = (U) HOSPICE DAYS USED SECONDARY
                                 5378 = (C) SERVICE DATE < AGE 50
                                 5399 = (U) HOSPICE PERIOD NUM MATCH
                                 5410 = (U) INPAT DEDUCTABLE
                                 5425 = (U) PART B DEDUCTABLE CHECK
                                 5430 = (U) PART B DEDUCTABLE CHECK
                                 5450 = (U) PART B COMPARE MED EXPENSE
                                 5460 = (U) PART B COMPARE MED EXPENSE
                                 5499 = (U) MED EXPENSE TRAILER MISSING
                                 5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS
                                 5510 = (U) COIN DAYS/SNF COIN DAYS
                                 5515 = (U) FULL DAYS/COIN DAYS
                                 5516 = (U) SNF FULL DAYS/SNF COIN DAYS
                                 5520 = (U) LIFE RESERVE DAYS
                                 5530 = (U) UTIL DAYS/LIFE PSYCH DAYS
                                 5540 = (U) HH VISITS NE AFT PT B TRLR
                                 5550 = (E) SNF LESS THAN PT A EFF DATE
                                 5600 = (D) LOGICAL DUPE, COVERED
                                 5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123
                                 5602 = (D) LOGICAL DUPE, PANDE C, E OR I
                                 5603 = (D) LOGICAL DUPE, COVERED
                                 5605 = (D) POSS DUPE, OUTPAT REIMB
                                 5606 = (D) POSS DUPE, HOME HEALTH COVERED U
                                 5623 = (U) NON-PAY CODE IS P
                                 57X1 = (C) PROVIDER SPECIALITY CODE INVALID
                                 57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL
                                 57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND
                                 57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID
                                 5700 = (U) LINKED TO THREE SPELLS
                                 5701 = (C) DEMO ID=02,RIC NOT = 5
                                 5702 = (C) DEMO ID=02,INVALID PROVIDER NUM
                                 58X1 = (C) PROVIDER TYPE INVALID
                                 58X9 = (C) TYPE OF SERVICE INVALID
                                 5802 = (C) REIMB > $150,000
```

```
                              5803 = (C) UNITS/VISITS > 150
                              5804 = (C) UNITS/VISITS > 99
                              59XA = (C) PROST ORTH HCPCS/FROM DATE
                              59XB = (C) HCPCS/FROM DATE/TYPE P OR I
                              59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE
                              59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE
                              59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS
                              59XG = (C) CAPPED/FREQ-MAINT/PROST HCPCS
                              59XH = (C) HCPCS E0620/TYPE/DATE
                              59XI = (C) HCPCS E0627-9/ DATE < 1991
                              59XL = (C) HCPCS 00104 - TOS/POS
                              59X1 = (C) INVALID HCPCS/TOS COMBINATION
                              59X2 = (C) ASC IND/TYPE OF SERVICE INVALID
                              59X3 = (C) TOS INVALID TO MODIFIER
                              59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB
                              59X5 = (C) MAMMOGRAPHY FOR MALE
                              59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS
                              59X7 = (C) CAPPED-HCPCS/FROM DATE
                              59X8 = (C) FREQUENTLY MAINTAINED HCPCS
                              59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R
                              5901 = (U) ERROR CODE OF Q
                              60X1 = (C) ASSIGN IND INVALID
```

```
                              6000 = (U) ADJUSTMENT BILL SPELL DATA
                              6020 = (U) CURRENT SPELL DOEBA < 1990
                              6030 = (U) ADJUSTMENT BILL SPELL DATA
                              6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA
                              61X1 = (C) PAY PROCESS IND INVALID
                              61X2 = (C) DENIED CLAIM/NO DENIED LINE
                              61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES
                              61X4 = (C) RATE MISSING OR NON-NUMERIC
                              6100 = (C) REV 0001 NOT PRESENT ON CLAIM
                              6101 = (C) REV COMPUTED CHARGES NOT=TOTAL
                              6102 = (C) REV COMPUTED NON-COVERED/NON-COV
                              6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER
                              62XA = (C) PSYC OT PT/REIM/TYPE
                              62X1 = (C) DME/DATE/100% OR INVAL REIMB IND
                              62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED
                              62X8 = (C) KIDNEY DONO/TYPE/100%
                              62X9 = (C) PNEUM VACCINE/TYPE/100%
                              6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV
                              6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE
                              6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA
                              6260 = (U) HOSPICE ADJUSTMENT STAY DAYS
                              6261 = (U) HOSPICE ADJUSTMENT DAYS USED
                              6265 = (U) HOSPICE ADJUSTMENT DAYS USED
                              6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)
                              63X1 = (C) DEDUCT IND INVALID
                              63X2 = (C) DED/HCFA COINS IN PCOE/CABG
                              6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS
                              6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)
                              64X1 = (C) PROVIDER IND INVALID
                              6430 = (U) PART B DEDUCTABLE CHECK
                              65X1 = (C) PAYSCREEN IND INVALID
                              66?? = (D) POSS DUPE, CR/DB, DOC-ID
                              66XX = (D) POSS DUPE, CR/DB, DOC-ID
```

```
            66X1 = (C) UNITS AMOUNT INVALID
            66X2 = (C) UNITS IND > 0; AMT NOT VALID
            66X3 = (C) UNITS IND = 0; AMT > 0
            66X4 = (C) MT INDICATOR/AMOUNT
            6600 = (U) ADJUSTMENT BILL FULL DAYS
            6610 = (U) ADJUSTMENT BILL COIN DAYS
            6620 = (U) ADJUSTMENT BILL LIFE RESERVE
            6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
            67X1 = (C) UNITS INDICATOR INVALID
            67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0
            67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2
            67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1
            67X6 = (C) INVALID PROC FOR MT IND 2, ANEST
            67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD
            67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN
            6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS
            6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS
            68X1 = (C) INVALID HCPCS CODE
            68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092
            68X3 = (C) TYPE OF SERVICE = G /PROC CODE
            68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE
            68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC
            68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC
            68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.
            68X8 = (C) LINE ITEM INCORRECT OR DATE INVAL.
```

```
            69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL
            69X3 = (C) PROC CODE MOD = LL / TYPE = R
            69X6 = (C) PROC CODE MOD/NOT CAPPED
            69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL
            6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO
            6902 = (C) KRON IND AND NO-PAY CODE B OR N
            6903 = (C) KRON IND AND INPATIENT DEDUCT = 0
            6904 = (C) KRON IND AND TRANS CODE IS 4
            6910 = (C) REV CODES ON HOME HEALTH
            6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY
            6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO
            6913 = (C) REV CODE INVAL FOR OXYGEN
            6914 = (C) REV CODE INVAL FOR DME
            6915 = (C) PURCHASE OF RENT DME INVAL ON DATES
            6916 = (C) PURCHASE OF RENT DME INVAL ON DATES
            6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000
            6918 = (C) HCPCS INVALID ON DATE RANGES
            6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89
            6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33
            6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X
            6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274
            6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291
            6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL
            6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X
            6929 = (U) ADJUSTMENT BILL LIFE RESERVE
            6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
            7000 = (U) INVALID DOEBA/DOLBA
            7002 = (U) LESS THAN 60/61 BETWEEN SPELLS
            7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD
            71X1 = (C) SUBMITTED CHARGES INVALID
```

```
                          71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG
                          72X1 = (C) ALLOWED CHGS INVALID
                          72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE
                          72X3 = (C) DENIED LINE/ALLOWED CHARGES
                          73X1 = (C) SS NUMBER INVALID
                          73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING
                          74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT
                          76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL
                          77X1 = (C) PLACE OF SERVICE INVALID
                          77X2 = (C) PHYS THERAPY/PLACE
                          77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE
                          77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND
                          77X6 = (C) TOS=F, PL OF SER NOT = 24
                          7701 = (C) INCORRECT MODIFIER
                          7777 = (D) POSS DUPE, PART B DOC-ID
                          78XA = (C) MAMMOGRAPHY BEFORE 1991
                          78X1 = (C) THRU DATE INVALID
                          78X3 = (C) FROM DATE GREATER THAN THRU DATE
                          78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY
                          78X5 = (C) FROM DATE > PAID DATE/TYPE/100%
                          78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE
                          79X3 = (C) THRU DATE>RECD DATE/NOT DENIED
                          79X4 = (C) THRU DATE>PAID DATE/NOT DENIED
                          8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90
                          8028 = (E) NO ENTITLEMENT
                          8029 = (U) HH BEFORE PERIOD NOT PRESENT
                          8030 = (U) HH BILL VISITS > PT A REMAINING
                          8031 = (U) HH PT A REMAINING > 0
1       NCH_EDIT_TB                                          NCH EDIT TABLE
        -----------                                          --------------

                          8032 = (U) HH DOLBA+59 NOT GT FROM-DATE
                          8050 = (U) HH QUALIFYING INDICATOR = 1
                          8051 = (U) HH # VISITS NE AFT PT B APPLIED
                          8052 = (U) HH # VISITS NE AFT TRAILER
                          8053 = (U) HH BENEFIT PERIOD NOT PRESENT
                          8054 = (U) HH DOEBA/DOLBA NOT > 0
                          8060 = (U) HH QUALIFYING INDICATOR NE 1
                          8061 = (U) HH DATE NE DOLBA IN AFT TRLR
                          8062 = (U) HH NE PT-A VISITS REMAINING
                          81X1 = (C) NUM OF SERVICES INVALID
                          83X1 = (C) DIAGNOSIS INVALID
                          8301 = (C) HCPCS/GENDER DIAGNOSIS
                          8302 = (C) HCPCS G0101 V-CODE/SEX CODE
                          8304 = (C) BILL TYPE INVALID FOR G0123/4
                          84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC
                          84X2 = (C) INVALID DME START DATE
                          84X3 = (C) INVALID DME START DATE W/HCPCS
                          84X4 = (C) HCPCS G0101 V-CODE/SEX CODE
                          84X5 = (C) HCPCS CODE WITH INV DIAG CODE
                          86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS
                          88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD
                          9000 = (U) DOEBA/DOLBA CALC
                          9005 = (U) FULL/COINS HOSP DAYS CALC
                          9010 = (U) FULL/COINS SNF DAYS CALC
                          9015 = (U) LIFE RESERVE DAYS CALC
                          9020 = (U) LIFE PSYCH DAYS CALC
                          9030 = (U) INPAT DEDUCTABLE CALC
```

```
                                9040 = (U) DATA INDICATOR 1 SET
                                9050 = (U) DATA INDICATOR 2 SET
                                91X1 = (C) PATIENT REIMB/PAY-DENY CODE
                                92X1 = (C) PATIENT REIMB INVALID
                                92X2 = (C) PROVIDER REIMB INVALID
                                92X3 = (C) LINE DENIED/PATIENT-PROV REIMB
                                92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES
                                92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT
                                92X7 = (C) REIMB/PAY-DENY INCONSISTANT
                                9201 = (C) UPIN REF NAME OR INITIAL MISSING
                                9202 = (C) UPIN REF FIRST 3 CHAR INVALID
                                9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC
                                93X1 = (C) CASH DEDUCTABLE INVALID
                                93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
                                93X3 = (C) DENIED LINE/CASH DEDUCTIBLE
                                93X4 = (C) FROM DATE/CASH DEDUCTIBLE
                                93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
                                9300 = (C) UPIN OTHER, NOT PRESENT
                                9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM
                                9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
                                9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
                                94A1 = (C) NON-COVERED FROM DATE INVALID
                                94A2 = (C) NON-COVERED FROM > THRU DATE
                                94A3 = (C) NON-COVERED THRU DATE INVALID
                                94A4 = (C) NON-COVERED THRU DATE > ADMIT
                                94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
                                94C1 = (C) PR-PSYCH DAYS INVALID
                                94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
                                94F1 = (C) REIMBURSEMENT AMOUNT INVALID
                                94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
                                94G1 = (C) NO-PAY CODE INVALID
1       NCH_EDIT_TB                                           NCH EDIT TABLE
        -----------                                           --------------

                                94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
                                94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
                                94G4 = (C) NO PAY CODE = R & REIMB PRESENT
                                94X1 = (C) BLOOD LIMIT INVALID
                                94X2 = (C) TYPE/BLOOD DEDUCTIBLE
                                94X3 = (C) TYPE/DATE/LIMIT AMOUNT
                                94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
                                94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
                                9401 = (C) BLOOD DEDUCTIBLE AMT > 3
                                9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
                                9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
                                9404 = (C) INVALID GENDER CODE ON PRO-PAY
                                9407 = (C) INVALID DRG NUMBER
                                9408 = (C) INVALID DRG NUMBER (GLOBAL)
                                9409 = (C) HCFA DRG<>DRG ON BILL
                                9410 = (C) CABG/PCOE,INVALID DRG
                                95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87
                                95X2 = (C) MSP AMOUNT APPLIED INVALID
                                95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES
                                95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE
                                95X5 = (C) MSP CODE = G/DATE BEFORE 1987
                                95X6 = (C) MSP CODE = X AND NOT AVOIDED
                                95X7 = (C) MSP CODE VALID, CABG/PCOE
                                96X1 = (C) OTHER AMOUNTS INVALID
```

```
96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB
97X1 = (C) OTHER AMOUNTS INDICATOR INVALID
97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0
98X1 = (C) COINSURANCE INVALID
98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH
98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
99XX = (D) POSS DUPE, PART B DOC-ID
9901 = (C) REV CODE INVALID OR TRAILER CNT=0
9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE
9903 = (C) NO CLINIC VISITS FOR RHC
9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE
991X = (C) NO DATE OF SERVICE
9910 = (C) EDIT 9910 (NEW)
9911 = (C) BLOOD VERIFIED INVALID
9920 = (C) EDIT 9920 (NEW)
9930 = (C) EDIT 9930 (NEW)
9931 = (C) OUTPAT COINSURANCE VALUES
9933 = (C) RATE EXCEDES MAMMOGRAPHY LIMIT
9940 = (C) EDIT 9940 (NEW)
9942 = (C) EDIT 9942 (NEW)
9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612
9945 = (C) SERVICE DATE < 98001
9946 = (C) INVALID DIAGNOSIS CODE
9947 = (C) INVALID DIAGNOSIS CODE
9948 = (C) STAY FROM>96365,DIAG=V725
9960 = (C) MED CHOICE BUT HMO DATA MISSING
9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER
```

1   NCH_IP_PRO_APRVL_TYPE_TB   NCH Inpatient Peer Review Organization Approval Type Table
     -----------------------   --

```
1 = Approved by the PRO as billed - Code
    indicates that the claim has been
    reviewed by the PRO and has been fully
    approved including any day or cost
    outliers.
2 = Automatic approval - Does not apply to
    Medicare claim.
3 = Partial approval - Code indicates the
    bill has been reviewed by the PRO, and
    some portion (days or services) has
    been denied.  The from/thru dates of
    the approved portion of the stay,
    excluding grace days and any period at
    a noncovered level of care are shown
    on the bill.
4 = Admission denied - Code indicates the
    patient's need for inpatient services
    was reviewed upon admission and the
    PRO found that the stay was not
    medically necessary.
5 = Post payment review - Code indicates
    that any medical review will be
    completed after the claim is paid.
    The bill may be a day outlier, part of
```

```
                              the sample review, or may not be
                              reviewed.
                          6 = Pre-admission authorization - Pre-
                              admission authorization obtained, but
                              services not reviewed by the PRO.
                          7 THRU 9 = Reserved.

1     NCH_NEAR_LINE_RIC_TB                    NCH Near-Line Record Identification Code Table
      --------------------                    ---------------------------------------------


                          O = Part B physician/supplier claim
                              record (processed by local carriers;
                              can include DMEPOS services)
                          V = Part A institutional claim record
                              (inpatient (IP), skilled nursing
                              facility (SNF), christian science
                              (CS), home health agency (HHA), or
                              hospice)
                          W = Part B institutional claim record
                              (outpatient (OP), HHA)
                          U = Both Part A and B institutional home
                              health agency (HHA) claim records --
                              due to HHPPS and HHA A/B split.
                              (effective 10/00)
                          M = Part B DMEPOS claim record (processed
                              by DME Regional Carrier) (effective 10/93)

1     NCH_PATCH_TB                            NCH Patch Table
      ------------                            ---------------


                          01 = RRB Category Equatable BIC - changed (all
                               claim types) -- applied during the Nearline
                               'G' conversion to claims with NCH weekly
                               process date before 3/91.  Prior to Version
                               'H', patch indicator stored in redefined Claim
                               Edit Group, 3rd occurrence, position 2.
                          02 = Claim Transaction Code made consistent with
                               NCH payment/edit RIC code (OP and HHA) --
                               effective 3/94, CWFMQA began patch.  During
                               'H' conversion, patch applied to claims with
                               NCH weekly process date prior to 3/94.  Prior
                               to version 'H', patch indicator stored in
                               redefined Claim Edit Group, 4th occurrence,
                               position 1.
                          03 = Garbage/nonnumeric Claim Total Charge Amount
                               set to zeroes (Instnl) --  during the Version
                               'G' conversion, error occurred in the deriva-
                               tion of this field where the claim was missing
                               revenue center code = '0001'.  In 1994, patch
                               was applied to the OP and HHA SAFs only. (This
                               SAF patch indicator was stored in the redefined
                               Claim Edit Group, 4th occurrence, position 2).
                               During the 'H' ocnversion, patch applied to
                               Nearline claims where garbage or nonnumeric
                               values.
                          04 = Incorrect bene residence SSA standard county
```

```
                                       code '999' changed (all claim types) --
                                       applied during the Nearline 'G' conversion and
                                       ongoing through 4/21/94, calling EQSTZIP
                                       routine to claims with NCH weekly process
                                       date prior to 4/22/94.  Prior to Version 'H'
                                       patch indicator stored in redefined Claim
                                       Edit Group, 3rd occurrence, position 4.
                                  05 = Wrong century bene birth date corrected (all
                                       claim types) -- applied during Nearline 'H'
                                       conversion to all history where century
                                       greater than 1700 and less than 1850; if
                                       century less than 1700, zeroes moved.
                                  06 = Inconsistent CWF bene medicare status code
                                       made consistent with age (all claim types) --
                                       applied during Nearline 'H' conversion to all
                                       history and patched ongoing.  Bene age is
                                       calculated to determine the correct value;
                                       if greater than 64, 1st position MSC ='1';
                                       if less than 65, 1st position MSC = '2'.
                                  07 = Missing CWF bene mediare status code derived
                                       (all claim types) -- applied during Nearline
                                       'H' conversion to all history and patched
                                       ongoing, except claims with unknown DOB and/
                                       or Claim From Date='0' (left blank).   Bene
                                       age is calculated to determine missing value;
                                       if greater than 64, MSC='10'; if less than
                                       65, MSC = '20'.
                                  08 = Invalid NCH primary payer code set to blanks
                                       (Instnl) -- applied during Version 'H' con-
                                       version to claims with NCH weekly process
                                       date 10/1/93-10/30/95, where MSP values =
```

1   NCH_PATCH_TB   NCH Patch Table
        ------------   --------------

```
                                       invalid '0', '1', '2', '3' or '4' (caused
                                       by erroneous logic in HCFA program code,
                                       which was corrected on 11/1/95).
                                  09 = Zero CWF claim accretion date replaced with
                                       NCH weekly process date (all claim types)
                                       -- applied during Version 'H' conversion to
                                       Instnl and DMERC claims; applied during
                                       Version 'G' conversion to non-institutional
                                       (non-DMERC) claims.  Prior to Version 'H',
                                       patch indicator stored in redefined claim
                                       edit group, 3rd occurrence, position 1.
                                  10 = Multiple Revenue Center 0001 (Outpatient,
                                       HHA and Hospice) -- patch applied to 1998 &
                                       1999 Nearline and SAFs to delete any revenue
                                       codes that followed the first '0001' revenue
                                       center code.   The edit was applied across all
                                       institutional claim types, including Inpatient/
                                       SNF (the problem was only found with OP/HHA/
                                       Hospice claims).  The problem was corrected
                                       6/25/99.
                                  11 = Truncated claim total charge amount in the
                                       fixed portion replaced with the total charge
                                       amount in the revenue center 0001 amount field
                                       -- service years 1998 & 1999 patched during
```

```
                           quarterly merge.  The 1998 & 1999 SAFs were
                           corrected when finalized in 7/99.  The patch
                           was done for records with NCH Daily Process
                           Date 1/4/99 - 5/14/99.
              12 = Missing claim-level HHA Total Visit Count --
                   service years 1998, 1999 & 2000 patch applied
                   during Version 'I' conversion of both the
                   Nearline and SAFs.   Problem occurs in those
                   claims recovered during the missing claims
                   effort.
              13 = Inconsistent Claim MCO Paid Switch made consistent
                   with criteria used to identify an inpatient
                   encounter claim -- if MCO paid switch equal to blank
                   or '0' and ALL conditions are met to indicate an
                   inpatient encounter claim (bene enrolled in a risk
                   MCO during the service period), change the switch to
                   a '1'.  The patch was applied during the Version 'I'
                   conversion, for claims back to 7/1/97 service thru date.


1      NCH_STATE_SGMT_TB                        NCH State Segment Table
       -----------------                        -----------------------


              01 = Alabama
              02 = Alaska
              03 = Arizona
              04 = Arkansas
              05 = California
              06 = Colorado
              07 = Connecticut
              08 = Delaware
              09 = District of Columbia
              10 = Florida
              11 = Georgia
              12 = Hawaii
              13 = Idaho
              14 = Illinois
              15 = Indiana
              16 = Iowa
              17 = Kansas
              18 = Kentucky
              19 = Louisiana
              20 = Maine
              21 = Maryland
              22 = Massachusetts
              23 = Michigan
              24 = Minnesota
              25 = Mississippi
              26 = Missouri
              27 = Montana
              28 = Nebraska
              29 = Nevada
              30 = New Hampshire
              31 = New Jersey
              32 = New Mexico
              33 = New York
              34 = North Carolina
              35 = North Dakota
```

```
                      36 = Ohio
                      37 = Oklahoma
                      38 = Oregon
                      39 = Pennsylvania
                      40 = Puerto Rico
                      41 = Rhode Island
                      42 = South Carolina
                      43 = South Dakota
                      44 = Tennesee
                      45 = Texas
                      46 = Utah
                      47 = Vermont
                      48 = Virgin Islands
                      49 = Virginia
                      50 = Washington
                      51 = West Virginia
                      52 = Wisconsin
                      53 = Wyoming
                      54 = Africa
                      55 = Asia
                      56 = Canada
                      57 = Central America & West Indies
1      NCH_STATE_SGMT_TB                        NCH State Segment Table
       ----------------                         -----------------------

                      58 = Europe
                      59 = Mexico
                      60 = Oceania
                      61 = Philippines
                      62 = South America
                      63 = US Possessions
                      97 = Saipan - MP
                      98 = Guam
                      99 = American Samoa


1      PRVDR_NUM_TB                             Provider Number Table
       ------------                             ---------------------


       -   First two positions are the GEO SSA State Code.
            Exception: 55 = California
                       67 = Texas
                       68 = Florida

       -   Positions 3 and sometimes 4 are used as a
           category identifier.  The remaining positions
           are serial numbers.  The following blocks of numbers
           are reserved for the facilities indicated (NOTE:
           may have different meanings dependent on the Type
           of Bill (TOB):

           0001-0879   Short-term (general and specialty)
                       hospitals where TOB = 11X; ESRD
                       clinic where TOB = 72X
           0880-0899   Reserved for hospitals participating
                       in ORD demonstration projects where
                       TOB = 11X; ESRD clinic where TOB =
                       72X
```

```
0900-0999   Multiple hospital component in a
            medical complex (numbers retired)
            where TOB = 11X; ESRD clinic where
            TOB = 72X
1000-1199   Reserved for future use
1200-1224   Alcohol/drug hospitals (excluded
            from PPS-numbers retired)
            where TOB = 11X; ESRD clinic where
            TOB = 72X
1225-1299   Medical assistance facilities
            (Montana project); ESRD clinic where
            TOB = 72X
1300-1399   Rural Primary Care Hospital (RCPH) -
            eff. 10/97 changed to Critical Access
            Hospitals (CAH)
1400-1499   Continuation of 4900-4999 series (CMHC)
1500-1799   Hospices
1800-1989   Federally Qualified Health Centers
            (FQHC) where TOB = 73X; SNF (IP PTB)
            where TOB = 22X; HHA where TOB = 32X,
            33X, 34X
1990-1999   Christian Science Sanatoria
            (hospital services)
2000-2299   Long-term hospitals (excluded from PPS)
2300-2499   Chronic renal disease facilities
            (hospital based)
2500-2899   Non-hospital renal disease
            treatment centers
2900-2999   Independent special purpose renal
            dialysis facility (1)
3000-3024   Formerly tuberculosis hospitals
            (numbers retired)
3025-3099   Rehabilitation hospitals (excluded
            from PPS)
3100-3199   Continuation of Subunits of Nonprofit
            and Proprietary Home Health Agencies
            (7300-7399) Series (3) (eff. 4/96)
3200-3299   Continuation of 4800-4899 series (CORF)
```

```
3300-3399   Children's hospitals (excluded from PPS)
            where TOB = 11X; ESRD clinic where TOB =
            72X
3400-3499   Continuation of rural health clinics
            (provider-based) (3975-3999)
3500-3699   Renal disease treatment centers
            (hospital satellites)
3700-3799   Hospital based special purpose renal
            dialysis facility (1)
3800-3974   Rural health clinics (free-standing)
3975-3999   Rural health clinics (provider-based)
4000-4499   Psychiatric hospitals (excluded
            from PPS)
4500-4599   Comprehensive Outpatient
            Rehabilitation Facilities (CORF)
4600-4799   Community Mental Health Centers (CMHC);
            9/30/91 - 3/31/97 used for clinic OPT
```

```
                              where TOB = 74X
                4800-4899     Continuation of 4500-4599 series (CORF)
                                (eff. 10/95)
                4900-4999     Continuation of 4600-4799 series (CMHC)
                                (eff. 10/95); 9/30/91 - 3/31/97 used for
                                clinic OPT where TOB = 74X
                5000-6499     Skilled Nursing Facilities
                6500-6989     CMHC / Outpatient physical therapy services
                                where TOB = 74X; CORF where TOB =
                                75X
                6990-6999     Christian Science Sanatoria (skilled
                                nursing services)
                7000-7299     Home Health Agencies (HHA) (2)
                7300-7399     Subunits of 'nonprofit' and
                                'proprietary' Home Health Agencies (3)
                7400-7799     Continuation of 7000-7299 series
                7800-7999     Subunits of state and local governmental
                                Home Health Agencies (3)
                8000-8499     Continuation of 7400-7799 series (HHA)
                8500-8899     Continuation of rural health
                                center (provider based) (3400-3499)
                8900-8999     Continuation of rural health
                                center (free-standing) (3800-3974)
                9000-9499     Continuation of 8000-8499 series (HHA)
                                (eff. 10/95)
                9500-9999     Reserved for future use (eff. 8/1/98)
                                NOTE: 10/95-7/98 this series was
                                assigned to HHA's but rescinded - no
                                HHA's were ever assigned a number
                                from this series.

                Exception:

                P001-P999   Organ procurement organization

        (1)  These facilities (SPRDFS) will be assigned
             the same provider number whenever they
             are recertified.

        (2)  The 6400-6499 series of provider numbers
             in Iowa (16), South Dakota (43) and Texas (45)
```
1   PRVDR_NUM_TB   Provider Number Table
        ------------   --------------------
```
             have been used in reducing acute care costs (RACC)
             experiments.

        (3)  In Virginia (49), the series 7100-7299 has
             been reserved for statewide subunit components
             of the Virginia state home health agencies.

        (4)  Parent agency must have a number in the
             7000-7299, 7400-7799 or 8000-8499 series.

    NOTE:
      There is a special numbering system for units
       of hospitals that are excluded from prospective
       payment system (PPS) and hospitals with SNF
```

swing-bed designation. An alpha character in
the third position of the provider number
identifies the type of unit or swing-bed
designation as follows:

```
  S = Psychiatric unit (excluded from PPS)
  T = Rehabilitation unit (excluded from PPS)
  U = Short term/acute care swing-bed hospital
  V = Alcohol drug unit (prior to 10/87 only)
  W = Long term SNF swing-bed hospital
      (eff 3/91)
  Y = Rehab hospital swing-bed (eff 9/92)
  Z = Rural primary care swing-bed hospital
```

There is also a special numbering system for
assigning emergency hospital identification
numbers (non participating hospitals). The
sixth position of the provider number is as
follows:

```
  E = Non-federal emergency hospital
  F = Federal emergency hospital
```

1   PTNT_DSCHRG_STUS_TB   Patient Discharge Status Table
      ------------------   -----------------------------

        01 = Discharged to home/self care (routine
             charge).
        02 = Discharged/transferred to other short term
             general hospital for inpatient care.
        03 = Discharged/transferred to skilled
             nursing facility (SNF) - (For hospitals
             with an approved swing bed arrangement,
             use Code 61 - swing bed. For reporting
             discharges/transfers to a non-certified
             SNF, the hospital must use Code 04 - ICF.
        04 = Discharged/transferred to intermediate
             care facility (ICF).
        05 = Discharged/transferred to another type
             of institution for inpatient care (including
             distinct parts).
        06 = Discharged/transferred to home care of
             organized home health service organization.
        07 = Left against medical advice or discontinued
             care.
        08 = Discharged/transferred to home under
             care of a home IV drug therapy provider.
        09 = Admitted as an inpatient to this
             hospital (effective 3/1/91). In situa-
             tions where a patient is admitted before
             midnight of the third day following the
             day of an outpatient service, the out-
             patient services are considered inpatient.
        20 = Expired (did not recover - Christian
             Science patient).
        30 = Still patient.
        40 = Expired at home (hospice claims only)

```
41 = Expired in a medical facility such as
     hospital, SNF, ICF, or freestanding
     hospice. (Hospice claims only)
42 = Expired - place unknown (Hospice claims
     only)
50 = Hospice - home (eff. 10/96)
51 = Hospice - medical facility (eff. 10/96)
61 = Discharged/transferred within this insti-
     tution to a hospital-based Medicare
     approved swing bed (to be implemented in
     1999)
71 = Discharged/transferred/referred to another
     institution for outpatient services as
     specified by the discharge plan of care (to
     be implemented in 1999).
72 = Discharged/transferred/referred to this
     institution for outpatient services as
     specified by the discharge plan of care
     (to be implemented in 1999).
```

```
1     REV_CNTR_ANSI_TB                    Revenue Center ANSI Code Table
      ----------------                    -----------------------------
```

```
*******EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*******
**************POSITIONS 1 & 2 OF ANSI CODE**************
CO = Contractual Obligations -- this group code should
     be used when a contractual agreement between the
     payer and payee, or a regulatory requirement, re-
     sulted in an adjustment.  Generally, these adjust-
     ments are considered a write-off for the provider
     and are not billed to the patient.

CR = Corrections and Reversals -- this group code should
     be used for correcting a prior claim.  It applies
     when there is a change to a previously adjudicated
     claim.

OA = Other Adjustments -- this group code should be used
     when no other group code applies to the adjustment.

PI = Payer Initiated Reductions -- this group code should
     be used when, in the opinion of the payer, the adjust-
     ment is not the responsibility of the patient, but
     there is no supporting contract between the provider
     and the payer (i.e., medical review or professional
     review organization adjustments).

PR = Patient Responsibility -- this group should be used
     when the adjustment represents an amount that should
     be billed to the patient or insured.  This group
     would typically be used for deductible and copay
     adjustments.

***********Claim Adjustment Reason Codes***************
***********POSITIONS 3 through 5 of ANSI CODE**********

1 = Deductible Amount
```

```
                    2 = Coinsurance Amount
                    3 = Co-pay Amount
                    4 = The procedure code is inconsistent with the modifier
                        used or a required modifier is missing.
                    5 = The procedure code/bill type is inconsistent with the
                        place of service.
                    6 = The procedure code is inconsistent with the patient's
                        age.
                    7 = The procedure code is inconsistent with the patient's
                        gender.
                    8 = The procedure code is inconsistent with the provider
                        type.
                    9 = The diagnosis is inconsistent with the patient's age.
                   10 = The diagnosis is inconsistent with the patient's
                        gender.
                   11 = The diagnosis is inconsistent with the procedure.
                   12 = The diagnosis is inconsistent with the provider type.
                   13 = the date of death precedes the date of service.
                   14 = The date of birth follows the date of service.
                   15 = Claim/service adjusted because the submitted auth-
                        orization number is missing, invalid, or does not
                        apply to the billed services or provider.
                   16 = Claim/service lacks information which is needed for
  1      REV_CNTR_ANSI_TB                     Revenue Center ANSI Code Table
         ----------------                     -----------------------------

                        adjudication.
                   17 = Claim/service adjusted because requested information
                        was not provided or was insufficient/incomplete.
                   18 = Duplicate claim/service.
                   19 = Claim denied because this is a work-related injury/
                        illness and thus the liability of the Worker's Com-
                        pensation Carrier.
                   20 = Claim denied because this injury/illness is covered
                        by the liability carrier.
                   21 = Claim denied because this injury/illness is the
                        liability of the no-fault carrier.
                   22 = Claim adjusted because this care may be covered by
                        another payer per coordination of benefits.
                   23 = Claim adjusted because charges have been paid by
                        another payer.
                   24 = Payment for charges adjusted.  Charges are covered
                        under a capitation agreement/managed care plan.
                   25 = Payment denied.  Your Stop loss deductible has not
                        been met.
                   26 = Expenses incurred prior to coverage.
                   27 = Expenses incurred after coverage terminated.
                   28 = Coverage not in effect at the time the service was
                        provided.
                   29 = The time limit for filing has expired.
                   30 = Claim/service adjusted because the patient has not met
                        the required eligibility, spend down, waiting, or
                        residency requirements.
                   31 = Claim denied as patient cannot be identified as our
                        insured.
                   32 = Our records indicate that this dependent is not an
                        eligible dependent as defined.
                   33 = Claim denied.  Insured has no dependent coverage.
```

```
34 = Claim denied.  Insured has no coverage for newborns.
35 = Benefit maximum has been reached.
36 = Balance does not exceed copayment amount.
37 = Balance does not exceed deductible amount.
38 = Services not provided or authorized by designated
     (network) providers.
39 = Services denied at the time authorization/pre-certi-
     fication was requested.
40 = Charges do not meet qualifications for emergency/urgent
     care.
41 = Discount agreed to in Preferred Provider contract.
42 = Charges exceed our fee schedule or maximum allowable
     amount.
43 = Gramm-Rudman reduction.
44 = Prompt-pay discount.
45 = Charges exceed your contracted/legislated fee arrange-
     ment.
46 = This (these) service(s) is(are) not covered.
47 = This (these) diagnosis(es) is(are) not covered,
     missing, or are invalid.
48 = This (these) procedure(s) is(are) not covered.
49 = These are non-covered services because this is a
     routine exam or screening procedure done in conjunc-
     tion with a routine exam.
50 = These are non-covered services because this is not
     deemed a 'medical necessity' by the payer.
```

```
51 = These are non-covered services because this a pre-
     existing condition.
52 = The referring/prescribing/rendering provider is not
     eligible to refer/prescribe/order/perform the service
     billed.
53 = Services by an immediate relative or a member of the
     same household are not covered.
54 = Multiple physicians/assistants are not covered in this
     case.
55 = Claim/service denied because procedure/treatment is
     deemed experimental/investigational by the payer.
56 = Claim/service denied because procedure/treatment has
     not been deemed 'proven to be effective' by payer.
57 = Claim/service adjusted because the payer deems the
     information submitted does not support this level of
     service, this many services, this length of service, or
     this dosage.
58 = Claim/service adjusted because treatment was deemed by
     the payer to have been rendered in an inappropriate
     or invalid place of service.
59 = Charges are adjusted based on multiple surgery rules or
     concurrent anesthesia rules.
60 = Charges for outpatient services with the proximity to
     inpatient services are not covered.
61 = Charges adjusted as penalty for failure to obtain second
     surgical opinion.
62 = Claim/service denied/reduced for absence of, or exceeded,
     precertification/authorization.
63 = Correction to a prior claim. INACTIVE
```

```
64 = Denial reversed per Medical Review. INACTIVE
65 = Procedure code was incorrect.  This payment reflects the
     correct code. INACTIVE
66 = Blood Deductible.
67 = Lifetime reserve days. INACTIVE
68 = DRG weight. INACTIVE
69 = Day outlier amount.
70 = Cost outlier amount.
71 = Primary Payer amount.
72 = Coinsurance day. INACTIVE
73 = Administrative days. INACTIVE
74 = Indirect Medical Education Adjustment.
75 = Direct Medical Education Adjustment.
76 = Disproportionate Share Adjustment.
77 = Covered days. INACTIVE
78 = Non-covered days/room charge adjustment.
79 = Cost report days. INACTIVE
80 = Outlier days. INACTIVE
81 = Discharges. INACTIVE
82 = PIP days. INACTIVE
83 = Total visits. INACTIVE
84 = Capital adjustments. INACTIVE
85 = Interest amount. INACTIVE
86 = Statutory adjustment. INACTIVE
87 = Transfer amounts.
88 = Adjustment amount represents collection against
     receivable created in prior overpayment.
89 = Professional fees removed from charges.
90 = Ingredient cost adjustment.
```

1	REV_CNTR_ANSI_TB	Revenue Center ANSI Code Table

```
91 = Dispensing fee adjustment.
92 = Claim paid in full. INACTIVE
93 = No claim level adjustment. INACTIVE
94 = Process in excess of charges.
95 = Benefits adjusted.  Plan procedures not followed.
96 = Non-covered charges.
97 = Payment is included in allowance for another
     service/procedure.
98 = The hospital must file the Medicare claim for this
     inpatient non-physician service. INACTIVE
99 = Medicare Secondary Payer Adjustment Amount. INACTIVE
100 = Payment made to patient/insured/responsible party.
101 = Predetermination: anticipated payment upon comple-
      tion of services or claim ajudication.
102 = Major medical adjustment.
103 = Provider promotional discount (i.e. Senior citizen
      discount).
104 = Managed care withholding.
105 = Tax withholding.
106 = Patient payment option/election not in effect.
107 = Claim/service denied because the related or qualifying
      claim/service was not paid or identified on the claim.
108 = Claim/service reduced because rent/purchase guidelines
      were not met.
109 = Claim not covered by this payer/contractor.  You must
      send the claim to the correct payer/contractor.
```

```
              110 = Billing date predates service date.
              111 = Not covered unless the provider accepts assignment.
              112 = Claim/service adjusted as not furnished directly
                    to the patient and/or not documented.
              113 = Claim denied because service/procedure was provided
                    outside the United States or as a result of war.
              114 = Procedure/product not approved by the Food and Drug
                    Administration.
              115 = Claim/service adjusted as procedure postponed or
                    canceled.
              116 = Claim/service denied.  The advance indemnification
                    notice signed by the patient did not comply with
                    requirements.
              117 = Claim/service adjusted because transportation is only
                    covered to the closest facility that can provide
                    the necessary care.
              118 = Charges reduced for ESRD network support.
              119 = Benefit maximum for this time period has been reached.
              120 = Patient is covered by a managed care plan. INACTIVE
              121 = Indemnification adjustment.
              122 = Psychiatric reduction.
              123 = Payer refund due to overpayment.  INACTIVE
              124 = Payer refund amount - not our patient. INACTIVE
              125 = Claim/service adjusted due to a submission/billing
                    error(s).
              126 = Deductible - Major Medical.
              127 = Coinsurance - Major Medical.
              128 = Newborn's services are covered in the mother's
                    allowance.
              129 = Claim denied - prior processing information appears
                    incorrect.
              130 = Paper claim submission fee.
1     REV_CNTR_ANSI_TB                      Revenue Center ANSI Code Table
      ----------------                      -----------------------------

              131 = Claim specific negotiated discount.
              132 = Prearranged demonstration project adjustment.
              133 = The disposition of this claim/service is pending
                    further review.
              134 = Technical fees removed from charges.
              135 = Claim denied.  Interim bills cannot be processed.
              136 = Claim adjusted.  Plan procedures of a prior payer
                    were not followed.
              137 = Payment/Reduction for Regulatory Surcharges, Assess-
                    ments, Allowances or Health Related Taxes.
              138 = Claim/service denied.  Appeal procedures not
                    followed or time limits not met.
              139 = Contracted funding agreement - subscriber is employed
                    by the provider of services.
              140 = Patient/Insured health identification number and name
                    do not match.
              141 = Claim adjustment because the claim spans eligible
                    and ineligible periods of coverage.
              142 = Claim adjusted by the monthly Medicaid patient
                    liability amount.
              A0 = Patient refund amount
              A1 = Claim denied charges.
              A2 = Contractual adjustment.
```

```
                   A3 = Medicare Secondary Payer liability met. INACTIVE
                   A4 = Medicare Claim PPS Capital Day Outlier Amount.
                   A5 = Medicare Claim PPS Capital Cost Outlier Amount.
                   A6 = Prior hospitalization or 30 day transfer requirement
                        not met.
                   A7 = Presumptive Payment Adjustment.
                   A8 = Claim denied; ungroupable DRG.
                   B1 = Non-covered visits.
                   B2 = Covered visits. INACTIVE
                   B3 = Covered charges. INACTIVE
                   B4 = Late filing penalty.
                   B5 = Claim/service adjusted because coverage/program
                        guidelines were not met or were exceeded.
                   B6 = This service/procedure is adjusted when performed/
                        billed by this type of provider, by this type of
                        facility, or by a provider of this specialty.
                   B7 = This provider was not certified/eligible to be
                        paid for this procedure/service on this date of
                        service.
                   B8 = Claim/service not covered/reduced because alter-
                        native services were available, and should have
                        been utilized.
                   B9 = Services not covered because the patient is en-
                        rolled in a Hospice.
                   B10 = Allowed amount has been reduced because a com-
                         ponent of the basic procedure/test was paid.  The
                         beneficiary is not liable for more than the charge
                         limit for the basic procedure/test.
                   B11 = The claim/service has been transferred to the
                         proper payer/processor for processing.  Claim/
                         service not covered by this payer/processor.
                   B12 = Services not documented in patients' medical re-
                         cords.
                   B13 = Previously paid.  Payment for this claim/service
                         may have been provided in a previous payment.
```

1   REV_CNTR_ANSI_TB   Revenue Center ANSI Code Table
       ----------------   -----------------------------

```
                   B14 = Claim/service denied because only one visit or
                         consultation per physician per day is covered.
                   B15 = Claim/service adjusted because this procedure/
                         service is not paid separately.
                   B16 = Claim/service adjusted because 'New Patient'
                         qualifications were not met.
                   B17 = Claim/service adjusted because this service was
                         not prescribed by a physician, not prescribed
                         prior to delivery, the prescription is incomplete,
                         or the prescription is not current.
                   B18 = Claim/service denied because this procedure code/
                         modifier was invalid on the date of service or
                         claim submission.
                   B19 = Claim/service adjusted because of the finding of a
                         Review Organization.  INACTIVE
                   B20 = Charges adjusted because procedure/service was
                         partially or fully furnished by another provider.
                   B21 = The charges were reduced because the service/care
                         was partially furnished by another physician.
                         INACTIVE
```

```
          B22 = This claim/service is adjusted based on the
                diagnosis.
          B23 = Claim/service denied because this provider has
                failed an aspect of a proficiency testing program.
          W1 = Workers Compensation State Fee Schedule Adjustment.

1     REV_CNTR_APC_TB              Revenue Center Ambulatory Payment Classification (APC)
      ---------------              -----------------------------------------------------


          0001 = Photochemotherapy
          0002 = Fine needle Biopsy/Aspiration
          0003 = Bone Marrow Biopsy/Aspiration
          0004 = Level I Needle Biopsy/ Aspiration Except
                 Bone Marrow
          0005 = Level II Needle Biopsy /Aspiration Except
                 Bone Marrow
          0006 = Level I Incision & Drainage
          0007 = Level II Incision & Drainage
          0008 = Level III Incision & Drainage
          0009 = Nail Procedures
          0010 = Level I Destruction of Lesion
          0011 = Level II Destruction of Lesion
          0012 = Level I Debridement & Destruction
          0013 = Level II Debridement & Destruction
          0014 = Level III Debridement & Destruction
          0015 = Level IV Debridement & Destruction
          0016 = Level V Debridement & Destruction
          0017 = Level VI Debridement & Destruction
          0018 = Biopsy Skin, Subcutaneous Tissue or Mucous Membrane
          0019 = Level I Excision/ Biopsy
          0020 = Level II Excision/ Biopsy
          0021 = Level III Excision/ Biopsy
          0022 = Level IV Excision/ Biopsy
          0023 = Exploration Penetrating Wound
          0024 = Level I Skin Repair
          0025 = Level II Skin Repair
          0026 = Level III Skin Repair
          0027 = Level IV Skin Repair
          0029 = Incision/Excision Breast
          0030 = Breast Reconstruction/Mastectomy
          0031 = Hyperbaric Oxygen
          0032 = Placement Transvenous Catheters/Arterial Cutdown
          0033 = Partial Hospitalization
          0040 = Arthrocentesis & Ligament/Tendon Injection
          0041 = Arthroscopy
          0042 = Arthroscopically-Aided Procedures
          0043 = Closed Treatment Fracture Finger/Toe/Trunk
          0044 = Closed Treatment Fracture/Dislocation Except
                 Finger/Toe/Trunk
          0045 = Bone/Joint Manipulation Under Anesthesia
          0046 = Open/Percutaneous Treatment Fracture or Dislocation
          0047 = Arthroplasty without Prosthesis
          0048 = Arthroplasty with Prosthesis
          0049 = Level I Musculoskeletal Procedures Except Hand
                 and Foot
          0050 = Level II Musculoskeletal Procedures Except Hand
                 and Foot
```

```
                         0051 = Level III Musculoskeletal Procedures Except Hand
                                and Foot
                         0052 = Level IV Musculoskeletal Procedures Except Hand
                                and Foot
                         0053 = Level I Hand Musculoskeletal Procedures
                         0054 = Level II Hand Musculoskeletal Procedures
                         0055 = Level I Foot Musculoskeletal Procedures
                         0056 = Level II Foot Musculoskeletal Procedures
                         0057 = Bunion Procedures
1      REV_CNTR_APC_TB            Revenue Center Ambulatory Payment Classification (APC)
       --------------            -----------------------------------------------------

                         0058 = Level I Strapping and Cast Application
                         0059 = Level II Strapping and Cast Application
                         0060 = Manipulation Therapy
                         0070 = Thoracentesis/Lavage Procedures
                         0071 = Level I Endoscopy Upper Airway
                         0072 = Level II Endoscopy Upper Airway
                         0073 = Level III Endoscopy Upper Airway
                         0074 = Level IV Endoscopy Upper Airway
                         0075 = Level V Endoscopy Upper Airway
                         0076 = Endoscopy Lower Airway
                         0077 = Level I Pulmonary Treatment
                         0078 = Level II Pulmonary Treatment
                         0079 = Ventilation Initiation and Management
                         0080 = Diagnostic Cardiac Catheterization
                         0081 = Non-Coronary Angioplasty or Atherectomy
                         0082 = Coronary Atherectomy
                         0083 = Coronary Angiosplasty
                         0084 = Level I Electrophysiologic Evaluation
                         0085 = Level II Electrophysiologic Evaluation
                         0086 = Ablate Heart Dysrhythm Focus
                         0087 = Cardiac Electrophysiologic Recording/Mapping
                         0088 = Thrombectomy
                         0089 = Level I Implantation/Removal/Revision of Pacemaker,
                                AICD Vascular Device
                         0090 = Level II Implantation/Removal/Revision of Pacemaker,
                                AICD Vascular Device
                         0091 = Level I Vascular Ligation
                         0092 = Level II Vascular Ligation
                         0093 = Vascular Repair/Fistula Construction
                         0094 = Resuscitation and Cardioversion
                         0095 = Cardiac Rehabilitation
                         0096 = Non-Invasive Vascular Studies
                         0097 = Cardiovascular Stress Test
                         0098 = Injection of Sclerosing Solution
                         0099 = Continuous Cardiac Monitoring
                         0100 = Continuous ECG
                         0101 = Tilt Table Evaluation
                         0102 = Electronic Analysis of Pacemakers/other Devices
                         0109 = Bone Marrow Harvesting and Bone Marrow/Stem Cell
                                Transplant
                         0110 = Transfusion
                         0111 = Blood Product Exchange
                         0112 = Extracorporeal Photopheresis
                         0113 = Excision Lymphatic System
                         0114 = Thyroid/Lymphadenectomy Procedures
                         0116 = Chemotherapy Administration by Other Technique
```

```
                              Except Infusion
                  0117 = Chemotherapy Administration by Infusion Only
                  0118 = Chemotherapy Administration by Both Infusion and
                         Other Technique
                  0120 = Infusion Therapy Except Chemotherapy
                  0121 = Level I Tube changes and Repositioning
                  0122 = Level II Tube changes and Repositioning
                  0123 = Level III Tube changes and Repositioning
                  0130 = Level I Laparoscopy
                  0131 = Level II Laparoscopy
                  0132 = Level III Laparoscopy
                  0140 = Esophageal Dilation without Endoscopy
1       REV_CNTR_APC_TB            Revenue Center Ambulatory Payment Classification (APC)
        ---------------            -----------------------------------------------------

                  0141 = Upper GI Procedures
                  0142 = Small Intestine Endoscopy
                  0143 = Lower GI Endoscopy
                  0144 = Diagnostic Anoscopy
                  0145 = Therapeutic Anoscopy
                  0146 = Level I Sigmoidoscopy
                  0147 = Level II Sigmoidoscopy
                  0148 = Level I Anal/Rectal Procedure
                  0149 = Level II Anal/Rectal Procedure
                  0150 = Level III Anal/Rectal Procedure
                  0151 = Endoscopic Retrograde Cholangio-Pancreatography (ERCP)
                  0152 = Percutaneous Biliary Endoscopic Procedures
                  0153 = Peritoneal and Abdominal Procedures
                  0154 = Hernia/Hydrocele Procedures
                  0157 = Colorectal Cancer Screening: Barium Enema
                         (Not subject to National coinsurance)
                  0158 = Colorectal Cancer Screening: Colonoscopy
                         Not subject to National coinsurance.  Minimum
                         unadjusted coinsurance is 25% of the payment rate.
                         Payment rate is lower of the HOPD payment rate or
                         the Ambulatory Surgical Center payment.
                  0159 = Colorectal Cancer Screening: Flexible Sigmoidoscopy
                         Not subject to National coinsurance.  Minimum
                         unadjusted coinsurance is 25% of the payment rate.
                         Payment rate is lower of the HOPD payment rate or
                         the Ambulatory Surgical Center payment.
                  0160 = Level I Cystourethroscopy and other Genitourinary
                         Procedures
                  0161 = Level II Cystourethroscopy and other Genitourinary
                         Procedures
                  0162 = Level III Cystourethroscopy and other Genitourinary
                         Procedures
                  0163 = Level IV Cystourethroscopy and other Genitourinary
                         Procedures
                  0164 = Level I  Urinary and Anal Procedures
                  0165 = Level II  Urinary and Anal Procedures
                  0166 = Level I Urethral Procedures
                  0167 = Level II Urethral Procedures
                  0168 = Level III Urethral Procedures
                  0169 = Lithotripsy
                  0170 = Dialysis for Other Than ESRD Patients
                  0180 = Circumcision
                  0181 = Penile Procedures
```

```
                         0182 = Insertion of Penile Prosthesis
                         0183 = Testes/Epididymis Procedures
                         0184 = Prostate Biopsy
                         0190 = Surgical Hysteroscopy
                         0191 = Level I Female Reproductive Procedures
                         0192 = Level II Female Reproductive Procedures
                         0193 = Level III Female Reproductive Procedures
                         0194 = Level IV Female Reproductive Procedures
                         0195 = Level V Female Reproductive Procedures
                         0196 = Dilatation & Curettage
                         0197 = Infertility Procedures
                         0198 = Pregnancy and Neonatal Care Procedures
                         0199 = Vaginal Delivery
                         0200 = Therapeutic Abortion
                         0201 = Spontaneous Abortion
1        REV_CNTR_APC_TB          Revenue Center Ambulatory Payment Classification (APC)
         ---------------          -----------------------------------------------------

                         0210 = Spinal Tap
                         0211 = Level I Nervous System Injections
                         0212 = Level II Nervous System Injections
                         0213 = Extended EEG Studies and Sleep Studies
                         0214 = Electroencephalogram
                         0215 = Level I Nerve and Muscle Tests
                         0216 = Level II Nerve and Muscle Tests
                         0217 = Level III Nerve and Muscle Tests
                         0220 = Level I Nerve Procedures
                         0221 = Level II Nerve Procedures
                         0222 = Implantation of Neurological Device
                         0223 = Level I Revision/Removal Neurological Device
                         0224 = Level II Revision/Removal Neurological Device
                         0225 = Implantation of Neurostimulator Electrodes
                         0230 = Level I Eye Tests
                         0231 = Level II Eye Tests
                         0232 = Level I Anterior Segment Eye
                         0233 = Level II Anterior Segment Eye
                         0234 = Level III Anterior Segment Eye Procedures
                         0235 = Level I Posterior Segment Eye Procedures
                         0236 = Level II Posterior Segment Eye Procedures
                         0237 = Level III Posterior Segment Eye Procedures
                         0238 = Level I Repair and Plastic Eye Procedures
                         0239 = Level II Repair and Plastic Eye Procedures
                         0240 = Level III Repair and Plastic Eye Procedures
                         0241 = Level IV Repair and Plastic Eye Procedures
                         0242 = Level V Repair and Plastic Eye Procedures
                         0243 = Strabismus/Muscle Procedures
                         0244 = Corneal Transplant
                         0245 = Cataract Procedures without IOL Insert
                         0246 = Cataract Procedures with IOL Insert
                         0247 = Laser Eye Procedures Except Retinal
                         0248 = Laser Retinal Procedures
                         0250 = Nasal Cauterization/Packing
                         0251 = Level I ENT Procedures
                         0252 = Level II ENT Procedures
                         0253 = Level III ENT Procedures
                         0254 = Level IV ENT Procedures
                         0256 = Level V ENT Procedures
                         0257 = Implantation of Cochlear Device
```

```
                         0258 = Tonsil and Adenoid Procedures
                         0260 = Level I Plain Film Except Teeth
                         0261 = Level II Plain Film Except Teeth Including Bone
                                Density Measurement
                         0262 = Plain Film of Teeth
                         0263 = Level I Miscellaneous Radiology Procedures
                         0264 = Level II Miscellaneous Radiology Procedures
                         0265 = Level I Diagnostic Ultrasound Except Vascular
                         0266 = Level II Diagnostic Ultrasound Except Vascular
                         0267 = Vascular Ultrasound
                         0268 = Guidance Under Ultrasound
                         0269 = Echocardiogram Except Transesophageal
                         0270 = Transesophageal Echocardiogram
                         0271 = Mammography
                         0272 = Level I Fluoroscopy
                         0273 = Level II Fluoroscopy
                         0274 = Myelography
                         0275 = Arthrography
1        REV_CNTR_APC_TB              Revenue Center Ambulatory Payment Classification (APC)
         ---------------             ------------------------------------------------------

                         0276 = Level I Digestive Radiology
                         0277 = Level II Digestive Radiology
                         0278 = Diagnostic Urography
                         0279 = Level I Diagnostic Angiography and Venography
                                Except Extremity
                         0280 = Level II Diagnostic Angiography and Venography
                                Except Extremity
                         0281 = Venography of Extremity
                         0282 = Level I Computerized Axial Tomography
                         0283 = Level II Computerized Axial Tomography
                         0284 = Magnetic Resonance Imaging
                         0285 = Positron Emission Tomography (PET)
                         0286 = Myocardial Scans
                         0290 = Standard Non-Imaging Nuclear Medicine
                         0291 = Level I Diagnostic Nuclear Medicine Excluding
                                Myocardial Scans
                         0292 = Level II Diagnostic Nuclear Medicine Excluding
                                Myocardial Scans
                         0294 = Level I Therapeutic Nuclear Medicine
                         0295 = Level II Therapeutic Nuclear Medicine
                         0296 = Level I Therapeutic Radiologic Procedures
                         0297 = Level II Therapeutic Radiologic Procedures
                         0300 = Level I Radiation Therapy
                         0301 = Level II Radiation Therapy
                         0302 = Level III Radiation Therapy
                         0303 = Treatment Device Construction
                         0304 = Level  I Therapeutic Radiation Treatment
                                Preparation
                         0305 = Level II Therapeutic Radiation Treatment
                                Preparation
                         0310 = Level III Therapeutic Radiation Treatment
                                Preparation
                         0311 = Radiation Physics Services
                         0312 = Radioelement Applications
                         0313 = Brachytherapy
                         0314 = Hyperthermic Therapies
                         0320 = Electroconvulsive Therapy
```

```
                                      0321 = Biofeedback and Other Training
                                      0322 = Brief Individual Psychotherapy
                                      0323 = Extended Individual Psychotherapy
                                      0324 = Family Psychotherapy
                                      0325 = Group Psychotherapy
                                      0330 = Dental Procedures
                                      0340 = Minor Ancillary Procedures
                                      0341 = Immunology Tests
                                      0342 = Level I Pathology
                                      0343 = Level II Pathology
                                      0344 = Level III Pathology
                                      0354 = Administration of Influenza Vaccine (Not
                                             subject to national coinsurance)
                                      0355 = Level I Immunizations
                                      0356 = Level II Immunizations
                                      0357 = Level III Immunizations
                                      0358 = Level IV Immunizations
                                      0359 = Injections
                                      0360 = Level I Alimentary Tests
                                      0361 = Level II Alimentary Tests
                                      0362 = Fitting of Vision Aids
1        REV_CNTR_APC_TB                Revenue Center Ambulatory Payment Classification (APC)
         --------------                 ------------------------------------------------------

                                      0363 = Otorhinolaryngologic Function Tests
                                      0364 = Level I Audiometry
                                      0365 = Level II Audiometry
                                      0366 = Electrocardiogram (ECG)
                                      0367 = Level I Pulmonary Test
                                      0368 = Level II Pulmonary Test
                                      0369 = Level III Pulmonary Test
                                      0370 = Allergy Tests
                                      0371 = Allergy Injections
                                      0372 = Therapeutic Phlebotomy
                                      0373 = Neuropsychological Testing
                                      0374 = Monitoring Psychiatric Drugs
                                      0600 = Low Level Clinic Visits
                                      0601 = Mid Level Clinic Visits
                                      0602 = High Level Clinic Visits
                                      0603 = Interdisciplinary Team Conference
                                      0610 = Low Level Emergency Visits
                                      0611 = Mid Level Emergency Visits
                                      0612 = High Level Emergency Visits
                                      0620 = Critical Care
                                      0701 = Strontium (eligible for pass-through payments)
                                      0702 = Samariam (eligible for pass-through payments)
                                      0704 = Satumomab Pendetide (eligible for pass-through
                                             payments)
                                      0705 = Tc99 Tetrofosmin (eligible for pass-through
                                             payments)
                                      0725 = Leucovorin Calcium (eligible for pass-through
                                             payments)
                                      0726 = Dexrazoxane Hydrochloride (eligible for pass-)
                                             through payments)
                                      0727 = Injection, Etidronate Disodium (eligible for
                                             pass-through payments)
                                      0728 = Filgrastim (G-CSF) (eligible for pass-through
                                             payments)
```

```
                    0730 = Pamidronate Disodium (eligible for pass-through
                           payments)
                    0731 = Sargramostim (GM-CSF) (eligible for pass-through
                           payments)
                    0732 = Mesna (eligible for pass-through payments)
                    0733 = Epoetin Alpha (eligible for pass-through)
                           payments)
                    0750 = Dolasetron Mesylate 10 mg (eligible for pass-
                           through payments)
                    0754 = Metoclopramide HCL (eligible for pass-through
                           payments)
                    0755 = Thiethylperazine Maleate (eligible for pass-through
                           payments)
                    0761 = Oral Substitute for IV Antiemtic (eligible for pass-
                           through payments)
                    0762 = Dronabinol (elibible for pass-through payments)
                    0763 = Dolasetron Mesylate 100 mg Oral (eligible for
                           pass-through payments)
                    0764 = Granisetron HCL, 100 mcg (eligible for pass-
                           through payments)
                    0765 = Granisetron HCL, 1mg Oral (eligible for pass-
                           through payments)
                    0768 = Ondansetron Hydrochloride per 1 mg Injection
                           (eligible for pass-through payments)
1       REV_CNTR_APC_TB             Revenue Center Ambulatory Payment Classification (APC)
        ---------------             ------------------------------------------------------

                    0769 = Ondansetron Hydrochloride 8 mg oral
                           (eligible for pass-through payments)
                    0800 = Leuprolide Acetate per 3.75 mg (eligible for
                           pass-through payments)
                    0801 = Cyclophosphamide (eligible for pass-through
                           payments)
                    0802 = Etoposide (eligible for pass-through payments)
                    0803 = Melphalan (eligible for pass-through payments)
                    0807 = Aldesleukin single use vial (eligible for pass-
                           through payments)
                    0809 = BCG (Intravesical) one vial (eligible for pass-
                           through payments)
                    0810 = Goserelin Acetate Implant, per 3.6 mg (eligible for
                           pass-through payments)
                    0811 = Carboplatin 50 mg (eligible for pass-through
                           payments)
                    0812 = Carmustine 100 mg (eligible for pass-through
                           payments)
                    0813 = Cisplatin 10 mg (eligible for pass-through
                           payments)
                    0814 = Asparaginase, 10,000 units (eligible for pass-
                           through payments)
                    0815 = Cyclophosphamide 100 mg (eligible for pass-
                           through payments)
                    0816 = Cyclophosphamide, Lyophilized 100 mg (eligible
                           for pass-through payments)
                    0817 = Cytrabine 100 mg (eligible for pass-through
                           payments)
                    0818 = Dactinomycin 0.5 mg (eligible for pass-through
                           payments)
                    0819 = Dacarbazine 100 mg (eligible for pass-through
```

```
                         payments)
          0820 = Daunorubicin HCI 10 mg (eligible for pass-through
                 payments)
          0821 = Daunorubicin Citrate, Liposomal Formulation, 10 mg
                 (eligible for pass-through payments)
          0822 = Diethylstibestrol Diphosphate 250 mg
                 (eligible for pass-through payments)
          0823 = Docetaxel 20 mg (eligible for pass-through
                 payments)
          0824 = Etoposide 10 mg (eligible for pass-through
                 payments)
          0826 = Methotrexate Oral 2.5 mg (eligible for pass-through
                 payments)
          0827 = Floxuridine 500 mg (eligible for pass-through
                 payments)
          0828 = Gemcitabine HCL 200 mg (eligibile for pass-
                 through payments)
          0830 = Irinotecan 20 mg (eligible for pass-through
                 payments)
          0831 = Ifosfamide per 1 gram (eligible for pass-through
                 payments)
          0832 = Idarubicin Hydrochloride 5 mg (eligible for pass-
                 through payments)
          0833 = Interferon Alfacon-1, Recombinant, 1 mcg
                 (eligible for pass-through payments)
          0834 = Interferon,  Alfa-2A, Recombinant 3 million units
                 (eligible for pass-through payments)
```

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)
	---------------	--

```
          0836 = Interferon,  Alfa-2B, Recombinant, 1 million units
                 (eligible for pass-through payments)
          0838 = Interferon, Gamma 1-B, 3 million units
                 (eligible for pass-through payments)
          0839 = Mechlorethamine HCI 10 mg
                 (eligible for pass-through payments)
          0840 = Melphalan HCI 50 mg (eligible for pass-
                 through payments)
          0841 = Methotrexate Sodium 5 mg (eligible for pass-
                 through payments)
          0842 = Fludarabine Phosphate 50 mg (eligible for pass-
                 through payments)
          0843 = Pegaspargase per single dose vial (eligible for
                 pass-through payments)
          0844 = Pentostatin 10 mg (eligible for pass-through
                 payments)
          0847 = Doxorubicin HCL 10 mg (eligible for pass-through
                 payments)
          0849 = Rituximab, 100 mg (eligible for pass-through
                 payments)
          0850 = Streptozocin 1 gm (eligible for pass-through
                 payments)
          0851 = Thiotepa 15 mg (eligible for pass-through pay-
                 ments)
          0852 = Topotecan 4 mg (eligible for pass-through payments)
          0853 = Vinblastine Sulfate 1 mg (eligible for pass-through
                 payments)
          0854 = Vincristine Sulfate 1 mg (eligible for pass-through
```

```
                                    payments)
                       0855 = Vinorelbine Tartrate per 10 mg (eligible for pass-
                              through payments)
                       0856 = Porfimer Sodium 75 mg (eligible for pass-through
                              payments)
                       0857 = Bleomycin Sulfate 15 units (eligible for pass-through
                              payments)
                       0858 = Cladribine, 1mg (eligible for pass-through payments)
                       0859 = Fluorouracil (eligible for pass-through payments)
                       0860 = Plicamycin 2.5 mg (eligible for pass-through payments)
                       0861 = Leuprolide Acetate 1 mg (eligible for pass-through
                              payments)
                       0862 = Mitomycin, 5mg (eligible for pass-through payments)
                       0863 = Paclitaxel, 30mg (eligible for pass-through payments)
                       0864 = Mitoxantrone HCl,  per 5mg (eligible for pass-through
                              payments)
                       0865 = Interferon alfa-N3, 250,000 IU (eligible for pass-
                              through payments)
                       0884 = Rho (D) Immune Globulin, Human one dose pack
                              (eligible for pass-through payments)
                       0886 = Azathioprine,  50 mg oral
                              (Not subject to national coinsurance)
                       0887 = Azathioprine, Parenteral 100 mg, 20 ml each injection
                              (Not subject to national coinsurance)
                       0888 = Cyclosporine, Oral 100 mg
                              (Not subject to national coinsurance)
                       0889 = Cyclosporine, Parenteral
                              (Not subject to national coinsurance)
                       0890 = Lymphocyte Immune Globulin 50 mg/ ml, 5 ml each
                              (Not subject to national coinsurance)
  1       REV_CNTR_APC_TB              Revenue Center Ambulatory Payment Classification (APC)
          --------------              ------------------------------------------------------

                       0891 = Tacrolimus per 1 mg oral
                              (Not subject to national coinsurance)
                       0892 = Daclizumab, Parenteral, 25 mg
                              (eligible for pass-through payments)
                       0900 = Injection, Alglucerase per 10 units
                              (eligible for pass-through payments)
                       0901 = Alpha I, Proteinase Inhibitor, Human per 10mg
                              (eligible for pass-through payments)
                       0902 = Botulinum Toxin, Type A per unit
                              (eligible for pass-through payments)
                       0903 = CMV Immune Globulin
                              (eligible for pass-through payments)
                       0905 = Immune Globulin per 500 mg
                              (eligible for pass-through payments)
                       0906 = RSV Immune Globulin
                              (eligible for pass-through payments)
                       0907 = Ganciclovir Sodium 500 mg injection
                              (Not subject to national coinsurance)
                       0908 = Tetanus Immune Globulin, Human, up to 250 units
                              (Not subject to national coinsurance)
                       0909 = Interferon Beta - 1a   33 mcg (eligible for pass-
                              through payments)
                       0910 = Interferon Beta - 1b   0.25 mg (eligible for pass-
                              through payments)
                       0911 = Streptokinase per 250,000 iu
```

```
                                        (Not subject to national coinsurance)
                          0913 = Ganciclovir 4.5  mg, Implant (eligible for pass-
                                   through payments)
                          0914 = Reteplase, 37.6 mg (Two Single Use Vials)
                                   (Not subject to national coinsurance)
                          0915 = Alteplase recombinant, 10mg
                                   (Not subject to national coinsurance)
                          0916 = Imiglucerase per unit (eligible for pass-through
                                   payments)
                          0917 = Dipyridamole, 10mg / Adenosine 6MG
                                   (Not subject to national coinsurance)
                          0918 = Brachytherapy Seeds, Any type, Each (eligible
                                   for pass-through payments)
                          0925 = Factor VIII (Antihemophilic Factor, Human) per iu
                                   (eligible for pass-through payments)
                          0926 = Factor VIII (Antihemophilic Factor, Porcine) per  iu
                                   (eligible for pass-through payments)
                          0927 = Factor VIII (Antihemophilic Factor, Recombinant)
                                   per iu (eligible for pass-through payments)
                          0928 = Factor IX,  Complex (eligible for pass-through
                                   payments)
                          0929 = Other Hemophilia Clotting Factors per iu (eligible
                                   for pass-through payments)
                          0930 = Antithrombin III (Human) per iu (eligible for pass-
                                   through payments)
                          0931 = Factor IX (Antihemophilic Factor, Purified, Non-
                                   Recombinant) (eligible for pass-through payments)
                          0932 = Factor IX (Antihemophilic Factor, Recombinant)
                                   (eligible for pass-through payments)
                          0949 = Plasma, Pooled Multiple Donor, Solvent/Detergent
                                   Treated, Frozen (not subject to national coinsurance)
                          0950 = Blood (Whole) For Transfusion (not subject to
                                   national coinsurance)
1         REV_CNTR_APC_TB               Revenue Center Ambulatory Payment Classification (APC)
          ---------------               -----------------------------------------------------

                          0952 = Cryoprecipitate (not subject to national coinsurance)
                          0953 = Fibrinogen Unit (not subject to national coinsurance)
                          0954 = Leukocyte Poor Blood (not subject to national
                                   coinsurance)
                          0955 = Plasma, Fresh Frozen (not subject to national
                                   coinsurance)
                          0956 = Plasma Protein Fraction (not subject to national
                                   coinsurance)
                          0957 = Platelet Concentrate (not subject to national
                                   coinsurance)
                          0958 = Platelet Rich Plasma (not subject to national
                                   coinsurance)
                          0959 = Red Blood Cells (not subject to national coinsurance)
                          0960 = Washed Red Blood Cells (not subject to national
                                   coinsurance)
                          0961 = Infusion, Albumin (Human) 5%, 500 ml
                                   (not subject to national coinsurance)
                          0962 = Infusion, Albumin (Human) 25%, 50 ml
                                   (not subject to national coinsurance)
                          0970 = New Technology - Level I     ($0 - $50)
                                   (not subject to national coinsurance)
                          0971 = New Technology - Level II    ($50 - $100)
```

```
                              (not subject to national coinsurance)
                    0972 = New Technology - Level III    ($100 - $200)
                              (not subject to national coinsurance)
                    0973 = New Technology - Level IV    ($200 - $300)
                              (not subject to national coinsurance)
                    0974 = New Technology - Level V     ($300 - $500)
                              (not subject to national coinsurance)
                    0975 = New Technology - Level VI    ($500 - $750)
                              (not subject to national coinsurance)
                    0976 = New Technology - Level VII    ($750 - $1000)
                              (not subject to national coinsurance)
                    0977 = New Technology - Level VIII  ($1000 - $1250)
                              (not subject to national coinsurance)
                    0978 = New Technology - Level IX    ($1250 - $1500)
                              (not subject to national coinsurance)
                    0979 = New Technology - Level X     ($1500 - $1750)
                              (not subject to national coinsurance)
                    0980 = New Technology - Level XI    ($1750 - $2000)
                              (not subject to national coinsurance)
                    0981 = New Technology - Level XII   ($2000 - $2500)
                              (not subject to national coinsurance)
                    0982 = New Technology - Level XIII   ($2500 - $3500)
                              (not subject to national coinsurance)
                    0983 = New Technology - Level XIV  ($3500 - $5000)
                              (not subject to national coinsurance)
                    0984 = New Technology - Level XV    ($5000 - $6000)
                              (not subject to national coinsurance)
                    7000 = Amifostine, 500 mg (eligible for pass-through
                              payments)
                    7001 = Amphotericin B lipid complex, 50 mg, Inj
                              (eligible for pass-through payments)
                    7002 = Clonidine, HCl, 1 MG (eligible for pass-
                              through payments)
                    7003 = Epoprostenol, 0.5 MG, inj (eligible for pass-
                              through payments)
                    7004 = Immune globulin intravenous human 5g, inj
1       REV_CNTR_APC_TB          Revenue Center Ambulatory Payment Classification (APC)
        ---------------          -----------------------------------------------------

                              (eligible for pass-through payments)
                    7005 = Gonadorelin hcI, 100 mcg (eligible for pass-
                              through payments)
                    7007 = Milrinone lacetate, per 5 ml, inj (not subject
                              to national coinsurance)
                    7010 = Morphine sulfate concentrate (preservative free)
                              per 10 mg (eligible for pass-through payments)
                    7011 = Oprelevekin, inj, 5 mg (eligible for pass-through
                              payments)
                    7012 = Pentamidine isethionate, 300 mg (eligible for
                              pass-through payments)
                    7014 = Fentanyl citrate, inj, up to 2 ml (eligible for
                              pass-through payments)
                    7015 = Busulfan, oral 2 mg (eligible for pass-through
                              payments)
                    7019 = Aprotinin, 10,000 kiu (eligible for pass-through
                              payments)
                    7021 = Baclofen, intrathecal, 50 mcg (eligible for pass-
                              through payments)
```

```
                         7022 = Elliotts B Solution, per ml (eligible for pass-
                                through payments)
                         7023 = Treatment for bladder calculi, I.e. Renacidin
                                per 500 ml (eligible for pass-through payments)
                         7024 = Corticorelin ovine triflutate, 0.1 mg
                                (eligible for pass-through payments)
                         7025 = Digoxin immune FAB (Ovine), 10 mg
                                (eligible for pass-through payments)
                         7026 = Ethanolamine oleate, 1000 ml
                                (eligible for pass-through payments)
                         7027 = Fomepizole, 1.5 G
                                (eligible for pass-through payments)
                         7028 = Fosphenytoin, 50 mg
                                (eligible for pass-through payments)
                         7029 = Glatiramer acetate, 25 mg
                                (eligible for pass-through payments)
                         7030 = Hemin, 1 mg
                                (eligible for pass-through payments)
                         7031 = Octreotide Acetate, 500 mcg
                                (eligible for pass-through payments)
                         7032 = Sermorelin acetate, 0.5 mg
                                (eligible for pass-through payments)
                         7033 = Somatrem, 5 mg
                                (eligible for pass-through payments)
                         7034 = Somatropin, 1 mg
                                (eligible for pass-through payments)
                         7035 = Teniposide, 50 mg
                                (eligible for pass-through payments)
                         7036 = Urokinase, inj, IV, 250,000 I.U.
                                (not subject to national coinsurance)
                         7037 = Urofollitropin, 75 I.U.
                                (eligible for pass-through payments)
                         7038 = Muromonab-CD3, 5 mg
                                (eligible for pass-through payments)
                         7039 = Pegademase bovine inj 25 I.U.
                                (eligible for pass-through payments)
                         7040 = Pentastarch 10% inj, 100 ml
                                (eligible for pass-through payments)
                         7041 = Tirofiban HCL, 0.5 mg
1        REV_CNTR_APC_TB              Revenue Center Ambulatory Payment Classification (APC)
         ---------------              ------------------------------------------------------

                                (not subject to national coinsurance)
                         7042 = Capecitabine, oral 150 mg
                                (eligible for pass-through payments)
                         7043 = Infliximab, 10 MG (eligible for pass-through
                                payments)
                         7045 = Trimetrexate Glucoronate (eligible for pass-
                                through payments)
                         7046 = Doxorubicin Hcl Liposome (eligible for pass-
                                through payments)

1 REV_CNTR_DDCTBL_COINSRNC_TB                 Revenue Center Deductible Coinsurance Code
  --------------------------                  -----------------------------------------

                         0 = Charges are subject to deductible
                             and coinsurance
```

```
                      1 = Charges are not subject to deductible
                      2 = Charges are not subject to coinsurance
                      3 = Charges are not subject to deductible
                          or coinsurance
                      4 = No charge or units associated with this
                          revenue center code.  (For multiple
                          HCPCS per single revenue center code)

                      For revenue center code 0001, the following
                      MSP override values may be present:

                      M = Override code; EGHP services involved
                           (eff 12/90 for non-institutional claims;
                           10/93 for institutional claims)
                      N = Override code; non-EGHP services involved
                           (eff 12/90 for non-institutional claims;
                           10/93 for institutional claims)
                      X = Override code: MSP cost avoided
                           (eff 12/90 for non-institutional claims;
                           10/93 for institutional claims)

   1   REV_CNTR_PMT_MTHD_IND_TB               Revenue Center Payment Method Indicator Table
       -----------------------                ---------------------------------------------


                      **********Service Indicator**************
                      ********** 1st position ******************
                      A = Services not paid under OPPS
                      C = Inpatient procedure
                      E = Noncovered items or services
                      F = Corneal issue acquistion
                      G = Current drug or biological pass-through
                      H = Device pass-through
                      J = New drug or new biological pass-through
                      N = Packaged incidental service
                      P = Partial hospitalization services
                      S = Significant procedure not subject to
                          multiple procedure discounting
                      T = Significant procedure subject to multiple
                          procedure discounting
                      V = Medical visit to clinic or emergency
                          department
                      X = Ancillary service

                      **********Payment Indicator**************
                      ********** 2nd position ******************
                      1 = Paid standard hospital OPPS amount
                          (service indicators S,T,V,X)
                      2 = Services not paid under OPPS (service
                          indicator A, or no HCPCS code and not
                          certain revenue center codes)
                      3 = Not paid (service indicators C & E)
                      4 = Acquisition cost paid (service indica-
                          tor F)
                      5 = Additional payment for current drug or
                          biological (service indicator G)
                      6 = Additional payment for device (service
                          indicator H)
```

```
          7 = Additional payment for new drug or new
              biological (service indicator J)
          8 = Paid partial hospitalization per diem
              (service indicator P)
          9 = No additional payment, payment included
              in line items with APCs (service
              indicator N, or no HCPCS code and certain
              revenue center codes, or HCPCS codes Q0082
              (activity therapy), G0129 (occupational
              therapy) or G0172 (partial hospitalization
              training)
```

```
1    REV_CNTR_PRICNG_IND_TB                    Revenue Center Pricing Indicator Table
     ---------------------                     --------------------------------------
```

```
          A = A valid HCPCS code not subject to a fee schedule payment.
              Reimbursement is calculated on provider submitted
              charges.
          B = A valid HCPCS code subject to the fee schedule payment.
              Reimbursement is the lesser of provider submitted
              charges or the fee schedule amount.
          D = a valid radiology HCPCS code subject to the Radiology
              Pricer and the rate is reflected as zeroes on the HCPCS
              file and cost report.  The Radiology Pricer treats this
              HCPCS as a non-covered service.  Reimbursement is cal-
              culated on provider submitted charges.
          E = A valid ASC HCPCS code subject to the ASC Pricer. The
              rate is reflected as zeroes on the HCPCS file.  The
              ASC Pricer determines the ASC payment rate and is re-
              ported on the cost report.
          F = A valid ESRD HCPCS code subject to the parameter rate.
              Reimbursement is the lesser of provider submitted
              charges or the fee schedule amount for non-dialysis
              HCPCS.  Reimbursement is calculated on the provider
              file rates for dialysis HCPCS.
          G = A valid HCPCS, code is subject to a fee schedule, but
              the rate is no longer present on the HCPCS file.
              Reimbursement is calculated on provider submitted
              charges.
          H = A valid DME HCPCS, code is subject to a fee schedule.
              The rates are reflected under the DME segment.  Reim-
              bursement is calculated either on a fee schedule, pro-
              vider submitted charges or the lesser of provider
              submitted, or the fee schedule depending o the cate-
              gory.
          I = A valid DME category 5 HCPCS, HCPCS is not found on
              the DME history record, but a match was found on HIC,
              category and generic code.  Claim must be reviewed by
              Medical Review before payment can be calculated.
          J = A valid DME HCPCS, no DME history is present, and a
              prescription is required before delivery.  Claim must
              be reviewed by Medical Review.
          K = A valid DME HCPCS, prescribed has been reviewed, and
              fee schedule payment is approved as prescription was
              present before delivery.
```

```
                     L = A valid TENS HCPCS, rental period is six months or
                         greater and must be reviewed by Medical Review.
                     M = A valid TENS HCPCS, Medical Review has approved the
                         rental charge in excess of five months.
                     R = A valid radiology HCPCS code and is subject to the
                         Radiology Pricer.  The rate is reported on the cost
                         report.  Reimbursement is calculated on provider
                         submitted charges.
                     S = Valid influenza/PPV HCPCS.  A fee amount is not
                         applicable.  The amount payable is present in the
                         covered charge field.  This amount is not subject
                         to the coinsurance and deductible.  This charge is
                         subject to the provider's reimbursement rate.
                     T = Valid HCPCS.  A fee amount is present.  The amount
                         payable should be the lower of the billed charge or
1    REV_CNTR_PRICNG_IND_TB                    Revenue Center Pricing Indicator Table
     ----------------------                    --------------------------------------

                     fee amount.  The system should compute the fee amount
                     by multiplying the covered units times the rate.
                     The fee amount is not subject to coinsurance and
                     deductible or provider's reimbursement rate.


1       REV_CNTR_TB                            Revenue Center Table
        -----------                            --------------------


                     0001 = Total charge
                     0022 = SNF claim paid under PPS submitted as TOB 21X,
                            effective for cost reporting periods begin-
                            ning on or after 7/1/98 (dates of service after
                            6/30/98).  NOTE:  This code may appear multiple
                            times on a claim to identify different HIPPS
                            Rate Code/assessment periods.
                     0023 = Home Health services paid under PPS submitted as
                            TOB 32X and 33X, effective 10/00.  This code may
                            appear multiple times on a claim to identify
                            different HIPPS/Home Health Resource Groups (HRG).
                     0100 = All inclusive rate-room and board plus ancillary
                     0101 = All inclusive rate-room and board
                     0110 = Private medical or general-general classification
                     0111 = Private medical or general-medical/surgical/GYN
                     0112 = Private medical or general-OB
                     0113 = Private medical or general-pediatric
                     0114 = Private medical or general-psychiatric
                     0115 = Private medical or general-hospice
                     0116 = Private medical or general-detoxification
                     0117 = Private medical or general-oncology
                     0118 = Private medical or general-rehabilitation
                     0119 = Private medical or general-other
                     0120 = Semi-private 2 bed (medical or general)
                            general classification
                     0121 = Semi-private 2 bed (medical or general)
                            medical/surgical/GYN
                     0122 = Semi-private 2 bed (medical or general)-OB
                     0123 = Semi-private 2 bed (medical or general)-pediatric
                     0124 = Semi-private 2 bed (medical or general)-psychiatric
                     0125 = Semi-private 2 bed (medical or general)-hospice
```

```
                        0126 = Semi-private 2 bed (medical or general)
                               detoxification
                        0127 = Semi-private 2 bed (medical or general)-oncology
                        0128 = Semi-private 2 bed (medical or general)
                               rehabilitation
                        0129 = Semi-private 2 bed (medical or general)-other
                        0130 = Semi-private 3 and 4 beds-general classification
                        0131 = Semi-private 3 and 4 beds-medical/surgical/GYN
                        0132 = Semi-private 3 and 4 beds-OB
                        0133 = Semi-private 3 and 4 beds-pediatric
                        0134 = Semi-private 3 and 4 beds-psychiatric
                        0135 = Semi-private 3 and 4 beds-hospice
                        0136 = Semi-private 3 and 4 beds-detoxification
                        0137 = Semi-private 3 and 4 beds-oncology
                        0138 = Semi_private 3 and 4 beds-rehabilitation
                        0139 = Semi-private 3 and 4 beds-other
                        0140 = Private (deluxe)-general classification
                        0141 = Private (deluxe)-medical/surgical/GYN
                        0142 = Private (deluxe)-OB
                        0143 = Private (deluxe)-pediatric
                        0144 = Private (deluxe)-psychiatric
                        0145 = Private (deluxe)-hospice
                        0146 = Private (deluxe)-detoxification
                        0147 = Private (deluxe)-oncology
                        0148 = Private (deluxe)-rehabilitation
                        0149 = Private (deluxe)-other
1        REV_CNTR_TB                        Revenue Center Table
         -----------                        --------------------

                        0150 = Room&Board ward (medical or general)
                               general classification
                        0151 = Room&Board ward (medical or general)
                               medical/surgical/GYN
                        0152 = Room&Board ward (medical or general)-OB
                        0153 = Room&Board ward (medical or general)-pediatric
                        0154 = Room&Board ward (medical or general)-psychiatric
                        0155 = Room&Board ward (medical or general)-hospice
                        0156 = Room&Board ward (medical or general)-detoxification
                        0157 = Room&Board ward (medical or general)-oncology
                        0158 = Room&Board ward (medical or general)-rehabilitation
                        0159 = Room&Board ward (medical or general)-other
                        0160 = Other Room&Board-general classification
                        0164 = Other Room&Board-sterile environment
                        0167 = Other Room&Board-self care
                        0169 = Other Room&Board-other
                        0170 = Nursery-general classification
                        0171 = Nursery-newborn
                               level I (routine)
                        0172 = Nursery-premature
                               newborn-level II (continuing care)
                        0173 = Nursery-newborn-level III (intermediate care)
                               (eff 10/96)
                        0174 = Nursery-newborn-level IV (intensive care)
                               (eff 10/96)
                        0175 = Nursery-neonatal ICU (obsolete eff 10/96)
                        0179 = Nursery-other
                        0180 = Leave of absence-general classification
                        0182 = Leave of absence-patient convenience charges
```

```
                              billable
                   0183 = Leave of absence-therapeutic leave
                   0184 = Leave of absence-ICF mentally retarded-any reason
                   0185 = Leave of absence-nursing home (hospitalization)
                   0189 = Leave of absence-other leave of absence
                   0190 = Subacute care - general classification
                          (eff. 10/97)
                   0191 = Subacute care - level I (eff. 10/97)
                   0192 = Subacute care - level II (eff. 10/97)
                   0193 = Subacute care - level III (eff. 10/97)
                   0194 = Subacute care - level IV (eff. 10/97)
                   0199 = Subacute care - other (eff 10/97)
                   0200 = Intensive care-general classification
                   0201 = Intensive care-surgical
                   0202 = Intensive care-medical
                   0203 = Intensive care-pediatric
                   0204 = Intensive care-psychiatric
                   0206 = Intensive care-post ICU; redefined as
                          intermediate ICU (eff 10/96)
                   0207 = Intensive care-burn care
                   0208 = Intensive care-trauma
                   0209 = Intensive care-other intensive care
                   0210 = Coronary care-general classification
                   0211 = Coronary care-myocardial infraction
                   0212 = Coronary care-pulmonary care
                   0213 = Coronary care-heart transplant
                   0214 = Coronary care-post CCU; redefined as
                          intermediate CCU (eff 10/96)
                   0219 = Coronary care-other coronary care
1        REV_CNTR_TB                        Revenue Center Table
         -----------                        --------------------

                   0220 = Special charges-general classification
                   0221 = Special charges-admission charge
                   0222 = Special charges-technical support charge
                   0223 = Special charges-UR service charge
                   0224 = Special charges-late discharge, medically
                          necessary
                   0229 = Special charges-other special charges
                   0230 = Incremental nursing charge rate-general
                          classification
                   0231 = Incremental nursing charge rate-nursery
                   0232 = Incremental nursing charge rate-OB
                   0233 = Incremental nursing charge rate-ICU (include
                          transitional care)
                   0234 = Incremental nursing charge rate-CCU (include
                          transitional care)
                   0235 = Incremental nursing charge rate-hospice
                   0239 = Incremental nursing charge rate-other
                   0240 = All inclusive ancillary-general classification
                   0241 = All inclusive ancillary-basic
                   0242 = All inclusive ancillary-comprehensive
                   0243 = All inclusive ancillary-specialty
                   0249 = All inclusive ancillary-other inclusive ancillary
                   0250 = Pharmacy-general classification
                   0251 = Pharmacy-generic drugs
                   0252 = Pharmacy-nongeneric drugs
                   0253 = Pharmacy-take home drugs
```

```
                    0254 = Pharmacy-drugs incident to other diagnostic service-
                           subject to payment limit
                    0255 = Pharmacy-drugs incident to radiology-
                           subject to payment limit
                    0256 = Pharmacy-experimental drugs
                    0257 = Pharmacy-non-prescription
                    0258 = Pharmacy-IV solutions
                    0259 = Pharmacy-other pharmacy
                    0260 = IV therapy-general classification
                    0261 = IV therapy-infusion pump
                    0262 = IV therapy-pharmacy services (eff 10/94)
                    0263 = IV therapy-drug supply/delivery (eff 10/94)
                    0264 = IV therapy-supplies (eff 10/94)
                    0269 = IV therapy-other IV therapy
                    0270 = Medical/surgical supplies-general classification
                           (also see 062X)
                    0271 = Medical/surgical supplies-nonsterile supply
                    0272 = Medical/surgical supplies-sterile supply
                    0273 = Medical/surgical supplies-take home supplies
                    0274 = Medical/surgical supplies-prosthetic/orthotic
                           devices
                    0275 = Medical/surgical supplies-pace maker
                    0276 = Medical/surgical supplies-intraocular lens
                    0277 = Medical/surgical supplies-oxygen-take home
                    0278 = Medical/surgical supplies-other implants
                    0279 = Medical/surgical supplies-other devices
                    0280 = Oncology-general classification
                    0289 = Oncology-other oncology
                    0290 = DME (other than renal)-general classification
                    0291 = DME (other than renal)-rental
                    0292 = DME (other than renal)-purchase of new DME
                    0293 = DME (other than renal)-purchase of used DME
1        REV_CNTR_TB                            Revenue Center Table
         -----------                            -------------------

                    0294 = DME (other than renal)-related to and listed as DME
                    0299 = DME (other than renal)-other
                    0300 = Laboratory-general classification
                    0301 = Laboratory-chemistry
                    0302 = Laboratory-immunology
                    0303 = Laboratory-renal patient (home)
                    0304 = Laboratory-non-routine dialysis
                    0305 = Laboratory-hematology
                    0306 = Laboratory-bacteriology & microbiology
                    0307 = Laboratory-urology
                    0309 = Laboratory-other laboratory
                    0310 = Laboratory pathological-general classification
                    0311 = Laboratory pathological-cytology
                    0312 = Laboratory pathological-histology
                    0314 = Laboratory pathological-biopsy
                    0319 = Laboratory pathological-other
                    0320 = Radiology diagnostic-general classification
                    0321 = Radiology diagnostic-angiocardiography
                    0322 = Radiology diagnostic-arthrography
                    0323 = Radiology diagnostic-arteriography
                    0324 = Radiology diagnostic-chest X-ray
                    0329 = Radiology diagnostic-other
                    0330 = Radiology therapeutic-general classification
```

```
       0331 = Radiology therapeutic-chemotherapy injected
       0332 = Radiology therapeutic-chemotherapy oral
       0333 = Radiology therapeutic-radiation therapy
       0335 = Radiology therapeutic-chemotherapy IV
       0339 = Radiology therapeutic-other
       0340 = Nuclear medicine-general classification
       0341 = Nuclear medicine-diagnostic
       0342 = Nuclear medicine-therapeutic
       0349 = Nuclear medicine-other
       0350 = Computed tomographic (CT) scan-general
              classification
       0351 = CT scan-head scan
       0352 = CT scan-body scan
       0359 = CT scan-other CT scans
       0360 = Operating room services-general classification
       0361 = Operating room services-minor surgery
       0362 = Operating room services-organ transplant,
              other than kidney
       0367 = Operating room services-kidney transplant
       0369 = Operating room services-other operating room
              services
       0370 = Anesthesia-general classification
       0371 = Anesthesia-incident to RAD and
              subject to the payment limit
       0372 = Anesthesia-incident to other diagnostic service
              and subject to the payment limit
       0374 = Anesthesia-acupuncture
       0379 = Anesthesia-other anesthesia
       0380 = Blood-general classification
       0381 = Blood-packed red cells
       0382 = Blood-whole blood
       0383 = Blood-plasma
       0384 = Blood-platelets
       0385 = Blood-leukocytes
       0386 = Blood-other components
1        REV_CNTR_TB                        Revenue Center Table
         -----------                        --------------------

       0387 = Blood-other derivatives (cryopricipatates)
       0389 = Blood-other blood
       0390 = Blood storage and processing-general
              classification
       0391 = Blood storage and processing-blood
              administration
       0399 = Blood storage and processing-other
       0400 = Other imaging services-general classification
       0401 = Other imaging services-diagnostic mammography
       0402 = Other imaging services-ultrasound
       0403 = Other imaging services-screening mammography
              (eff 1/1/91)
       0404 = Other imaging services-positron emission
              tomography (eff 10/94)
       0409 = Other imaging services-other
       0410 = Respiratory services-general classification
       0412 = Respiratory services-inhalation services
       0413 = Respiratory services-hyperbaric oxygen therapy
       0419 = Respiratory services-other
       0420 = Physical therapy-general classification
```

```
                       0421 = Physical therapy-visit charge
                       0422 = Physical therapy-hourly charge
                       0423 = Physical therapy-group rate
                       0424 = Physical therapy-evaluation or re-evaluation
                       0429 = Physical therapy-other
                       0430 = Occupational therapy-general classification
                       0431 = Occupational therapy-visit charge
                       0432 = Occupational therapy-hourly charge
                       0433 = Occupational therapy-group rate
                       0434 = Occupational therapy-evaluation or re-evaluation
                       0439 = Occupational therapy-other (may include
                              restorative therapy)
                       0440 = Speech language pathology-general classification
                       0441 = Speech language pathology-visit charge
                       0442 = Speech language pathology-hourly charge
                       0443 = Speech language pathology-group rate
                       0444 = Speech language pathology-evaluation or
                              re-evaluation
                       0449 = Speech language pathology-other
                       0450 = Emergency room-general classification
                       0451 = Emergency room-emtala emergency medical screening
                              services (eff 10/96)
                       0452 = Emergency room-ER beyond emtala screening
                              (eff 10/96)
                       0456 = Emergency room-urgent care (eff 10/96)
                       0459 = Emergency room-other
                       0460 = Pulmonary function-general classification
                       0469 = Pulmonary function-other
                       0470 = Audiology-general classification
                       0471 = Audiology-diagnostic
                       0472 = Audiology-treatment
                       0479 = Audiology-other
                       0480 = Cardiology-general classification
                       0481 = Cardiology-cardiac cath lab
                       0482 = Cardiology-stress test
                       0483 = Cardiology-Echocardiology
                       0489 = Cardiology-other
                       0490 = Ambulatory surgical care-general classification
1         REV_CNTR_TB                               Revenue Center Table
          -----------                               --------------------

                       0499 = Ambulatory surgical care-other
                       0500 = Outpatient services-general classification
                              (deleted 9/93)
                       0509 = Outpatient services-other (deleted 9/93)
                       0510 = Clinic-general classification
                       0511 = Clinic-chronic pain center
                       0512 = Clinic-dental center
                       0513 = Clinic-psychiatric
                       0514 = Clinic-OB-GYN
                       0515 = Clinic-pediatric
                       0516 = Clinic-urgent care clinic (eff 10/96)
                       0517 = Clinic-family practice clinic (eff 10/96)
                       0519 = Clinic-other
                       0520 = Free-standing clinic-general classification
                       0521 = Free-standing clinic-rural health clinic
                       0522 = Free-standing clinic-rural health home
                       0523 = Free-standing clinic-family practice
```

```
                0526 = Free-standing clinic-urgent care (eff 10/96)
                0529 = Free-standing clinic-other
                0530 = Osteopathic services-general classification
                0531 = Osteopathic services-osteopathic therapy
                0539 = Osteopathic services-other
                0540 = Ambulance-general classification
                0541 = Ambulance-supplies
                0542 = Ambulance-medical transport
                0543 = Ambulance-heart mobile
                0544 = Ambulance-oxygen
                0545 = Ambulance-air ambulance
                0546 = Ambulance-neo-natal ambulance
                0547 = Ambulance-pharmacy
                0548 = Ambulance-telephone transmission EKG
                0549 = Ambulance-other
                0550 = Skilled nursing-general classification
                0551 = Skilled nursing-visit charge
                0552 = Skilled nursing-hourly charge
                0559 = Skilled nursing-other
                0560 = Medical social services-general classification
                0561 = Medical social services-visit charge
                0562 = Medical social services-hourly charges
                0569 = Medical social services-other
                0570 = Home health aid (home health)-general
                       classification
                0571 = Home health aid (home health)-visit charge
                0572 = Home health aid (home health)-hourly charge
                0579 = Home health aid (home health)-other
                0580 = Other visits (home health)-general
                       classification (under HHPPS, not allowed
                       as covered charges)
                0581 = Other visits (home health)-visit charge
                       (under HHPPS, not allowed as covered charges)
                0582 = Other visits (home health)-hourly charge
                       (under HHPPS, not allowed as covered charges)
                0589 = Other visits (home health)-other
                       (under HHPPS, not allowed as covered charges)
                0590 = Units of service (home health)-general
                       classification (under HHPPS, not allowed
                       as covered charges)
                0599 = Units of service (home health)-other
1      REV_CNTR_TB                             Revenue Center Table
       -----------                             -------------------

                       (under HHPPS, not allowed as covered charges)
                0600 = Oxygen-general classification
                0601 = Oxygen-stat or port equip/supply or count
                0602 = Oxygen-stat/equip/under 1 LPM
                0603 = Oxygen-stat/equip/over 4 LPM
                0604 = Oxygen-stat/equip/portable add-on
                0610 = Magnetic resonance technology (MRT)-general
                       classification
                0611 = MRT/MRI-brain (including brainstem)
                0612 = MRT/MRI-spinal cord (including spine)
                0614 = MRT/MRI-other
                0615 = MRT/MRA-Head and Neck
                0616 = MRT/MRA-Lower Extremities
                0618 = MRT/MRA-other
```

```
0619 = MRT/Other MRI
0621 = Medical/surgical supplies-incident to radiology-
       subject to the payment limit - extension of 027X
0622 = Medical/surgical supplies-incident to other
       diagnostic service-subject to the payment limit -
       extension of 027X
0623 = Medical/surgical supplies-surgical dressings
       (eff 1/95) - extension of 027X
0624 = Medical/surgical supplies-medical investigational
       devices and procedures with FDA approved IDE's
       (eff 10/96) - extension of 027X
0630 = Drugs requiring specific identification-general
       classification
0631 = Drugs requiring specific identification-single drug
       source (eff 9/93)
0632 = Drugs requiring specific identification-multiple drug
       source (eff 9/93)
0633 = Drugs requiring specific identification-restrictive
       prescription (eff 9/93)
0634 = Drugs requiring specific identification-EPO under
       10,000 units
0635 = Drugs requiring specific identification-EPO 10,000
       units or more
0636 = Drugs requiring specific identification-detailed
       coding (eff 3/92)
0637 = Self-administered drugs administered in an
       emergency situation - not requiring detailed
       coding
0640 = Home IV therapy-general classification
       (eff 10/94)
0641 = Home IV therapy-nonroutine nursing
       (eff 10/94)
0642 = Home IV therapy-IV site care, central line
       (eff 10/94)
0643 = Home IV therapy-IV start/change peripheral line
       (eff 10/94)
0644 = Home IV therapy-nonroutine nursing, peripheral line
       (eff 10/94)
0645 = Home IV therapy-train patient/caregiver, central
       line (eff 10/94)
0646 = Home IV therapy-train disabled patient, central
       line (eff 10/94)
0647 = Home IV therapy-train patient/caregiver, peripheral
       line (eff 10/94)
```

1	REV_CNTR_TB	Revenue Center Table
	-----------	--------------------

```
0648 = Home IV therapy-train disabled patient, peripheral
       line (eff 10/94)
0649 = Home IV therapy-other IV therapy services
       (eff 10/94)
0650 = Hospice services-general classification
0651 = Hospice services-routine home care
0652 = Hospice services-continuous home care-1/2
0655 = Hospice services-inpatient care
0656 = Hospice services-general inpatient care
       (non-respite)
0657 = Hospice services-physician services
```

```
                       0659 = Hospice services-other
                       0660 = Respite care (HHA)-general classification
                              (eff 9/93)
                       0661 = Respite care (HHA)-hourly charge/skilled nursing
                              (eff 9/93)
                       0662 = Respite care (HHA)-hourly charge/home health aide/
                              homemaker (eff 9/93)
                       0670 = OP special residence charges - general
                              classification
                       0671 = OP special residence charges - hospital based
                       0672 = OP special residence charges - contracted
                       0679 = OP special residence charges - other special
                              residence charges
                       0700 = Cast room-general classification
                       0709 = Cast room-other
                       0710 = Recovery room-general classification
                       0719 = Recovery room-other
                       0720 = Labor room/delivery-general classification
                       0721 = Labor room/delivery-labor
                       0722 = Labor room/delivery-delivery
                       0723 = Labor room/delivery-circumcision
                       0724 = Labor room/delivery-birthing center
                       0729 = Labor room/delivery-other
                       0730 = EKG/ECG-general classification
                       0731 = EKG/ECG-Holter moniter
                       0732 = EKG/ECG-telemetry (include fetal monitering until
                              9/93)
                       0739 = EKG/ECG-other
                       0740 = EEG-general classification
                       0749 = EEG (electroencephalogram)-other
                       0750 = Gastro-intestinal services-general classification
                       0759 = Gastro-intestinal services-other
                       0760 = Treatment or observation room-general
                              classification
                       0761 = Treatment or observation room-treatment room
                              (eff 9/93)
                       0762 = Treatment or observation room-observation room
                              (eff 9/93)
                       0769 = Treatment or observation room-other
                       0770 = Preventative care services-general classification
                              (eff 10/94)
                       0771 = Preventative care services-vaccine administration
                              (eff 10/94)
                       0779 = Preventative care services-other (eff 10/94)
                       0780 = Telemedicine - general classification
                              (eff 10/97)
                       0789 = Telemedicine - telemedicine (eff 10/97)
1        REV_CNTR_TB                          Revenue Center Table
         -----------                          -------------------

                       0790 = Lithotripsy-general classification
                       0799 = Lithotripsy-other
                       0800 = Inpatient renal dialysis-general classification
                       0801 = Inpatient renal dialysis-inpatient hemodialysis
                       0802 = Inpatient renal dialysis-inpatient peritoneal
                              (non-CAPD)
                       0803 = Inpatient renal dialysis-inpatient CAPD
                       0804 = Inpatient renal dialysis-inpatient CCPD
```

```
                      0809 = Inpatient renal dialysis-other inpatient dialysis
                      0810 = Organ acquisition-general classification
                      0811 = Organ acquisition-living donor (eff 10/94);
                             prior to 10/94, defined as living donor kidney
                      0812 = Organ acquisition-cadaver donor (eff 10/94);
                             prior to 10/94, defined as cadaver donor kidney
                      0813 = Organ acquisition-unknown donor (eff 10/94)
                             prior to 10/94, defined as unknown donor kidney
                      0814 = Organ acquisition - unsuccessful organ search-
                             donor bank charges (eff 10/94); prior to 10/94,
                             defined as other kidney acquisition
                      0815 = Organ acquisition-cadaver donor-heart
                             (obsolete, eff 10/94)
                      0816 = Organ acquisition-other heart acquisition
                             (obsolete, eff 10/94)
                      0817 = Organ acquisition-donor-liver
                             (obsolete, eff 10/94)
                      0819 = Organ acquisition-other donor (eff 10/94);
                             prior to 10/94, defined as other
                      0820 = Hemodialysis OP or home dialysis-general
                             classification
                      0821 = Hemodialysis OP or home dialysis-hemodialysis-
                             composite or other rate
                      0822 = Hemodialysis OP or home dialysis-home supplies
                      0823 = Hemodialysis OP or home dialysis-home equipment
                      0824 = Hemodialysis OP or home dialysis-maintenance/100%
                      0825 = Hemodialysis OP or home dialysis-support services
                      0829 = Hemodialysis OP or home dialysis-other
                      0830 = Peritoneal dialysis OP or home-general
                             classification
                      0831 = Peritoneal dialysis OP or home-peritoneal-
                             composite or other rate
                      0832 = Peritoneal dialysis OP or home-home supplies
                      0833 = Peritoneal dialysis OP or home-home equipment
                      0834 = Peritoneal dialysis OP or home-maintenance/100%
                      0835 = Peritoneal dialysis OP or home-support services
                      0839 = Peritoneal dialysis OP or home-other
                      0840 = CAPD outpatient-general classification
                      0841 = CAPD outpatient-CAPD/composite or other rate
                      0842 = CAPD outpatient-home supplies
                      0843 = CAPD outpatient-home equipment
                      0844 = CAPD outpatient-maintenance/100%
                      0845 = CAPD outpatient-support services
                      0849 = CAPD outpatient-other
                      0850 = CCPD outpatient-general classification
                      0851 = CCPD outpatient-CCPD/composite or other rate
                      0852 = CCPD outpatient-home supplies
                      0853 = CCPD outpatient-home equipment
                      0854 = CCPD outpatient-maintenance/100%
                      0855 = CCPD outpatient-support services
1       REV_CNTR_TB                            Revenue Center Table
        -----------                            --------------------

                      0859 = CCPD outpatient-other
                      0880 = Miscellaneous dialysis-general classification
                      0881 = Miscellaneous dialysis-ultrafiltration
                      0882 = Miscellaneous dialysis-home dialysis aide visit
                             (eff 9/93)
```

```
0889 = Miscellaneous dialysis-other
0890 = Other donor bank-general classification; changed to
       reserved for national assignment (eff 4/94)
0891 = Other donor bank-bone; changed to
       reserved for national assignment (eff 4/94)
0892 = Other donor bank-organ (other than kidney); changed
       to reserved for national assignment (eff 4/94)
0893 = Other donor bank-skin; changed to
       reserved for national assignment (eff 4/94)
0899 = Other donor bank-other; changed to
       reserved for national assignment (eff 4/94)
0900 = Psychiatric/psychological treatments-general
       classification
0901 = Psychiatric/psychological treatments-electroshock
       treatment
0902 = Psychiatric/psychological treatments-milieu
       therapy
0903 = Psychiatric/psychological treatments-play
       therapy
0904 = Psychiatric/psychological treatments-activity
       therapy (eff 4/94)
0909 = Psychiatric/psychological treatments-other
0910 = Psychiatric/psychological services-general
       classification
0911 = Psychiatric/psychological services-rehabilitation
0912 = Psychiatric/psychological services-day care-
       redefined 10/97 to less Intensive
0913 = Psychiatric/psychological services-night care
       redefined 10/97 to Intensive
0914 = Psychiatric/psychological services-individual
       therapy
0915 = Psychiatric/psychological services-group therapy
0916 = Psychiatric/psychological services-family therapy
0917 = Psychiatric/psychological services-biofeedback
0918 = Psychiatric/psychological services-testing
0919 = Psychiatric/psychological services-other
0920 = Other diagnostic services-general classification
0921 = Other diagnostic services-peripheral vascular lab
0922 = Other diagnostic services-electromyelogram
0923 = Other diagnostic services-pap smear
0924 = Other diagnostic services-allergy test
0925 = Other diagnostic services-pregnancy test
0929 = Other diagnostic services-other
0940 = Other therapeutic services-general classification
0941 = Other therapeutic services-recreational therapy
0942 = Other therapeutic services-education/training
       (include diabetes diet training)
0943 = Other therapeutic services-cardiac rehabilitation
0944 = Other therapeutic services-drug rehabilitation
0945 = Other therapeutic services-alcohol
       rehabilitation
0946 = Other therapeutic services-routine complex
       medical equipment
```

```
0947 = Other therapeutic services-ancillary complex
       medical equipment (eff 3/92)
```

```
0949 = Other therapeutic services-other
0951 = Professional Fees-athletic training
0952 = Professional Fees-kinesiotherapy
0960 = Professional fees-general classification
0961 = Professional fees-psychiatric
0962 = Professional fees-ophthalmology
0963 = Professional fees-anesthesiologist (MD)
0964 = Professional fees-anesthetist (CRNA)
0969 = Professional fees-other
0971 = Professional fees-laboratory
0972 = Professional fees-radiology diagnostic
0973 = Professional fees-radiology therapeutic
0974 = Professional fees-nuclear medicine
0975 = Professional fees-operating room
0976 = Professional fees-respiratory therapy
0977 = Professional fees-physical therapy
0978 = Professional fees-occupational therapy
0979 = Professional fees-speech pathology
0981 = Professional fees-emergency room
0982 = Professional fees-outpatient services
0983 = Professional fees-clinic
0984 = Professional fees-medical social services
0985 = Professional fees-EKG
0986 = Professional fees-EEG
0987 = Professional fees-hospital visit
0988 = Professional fees-consultation
0989 = Professional fees-private duty nurse
0990 = Patient convenience items-general classification
0991 = Patient convenience items-cafeteria/guest tray
0992 = Patient convenience items-private linen service
0993 = Patient convenience items-telephone/telegraph
0994 = Patient convenience items-tv/radio
0995 = Patient convenience items-nonpatient room rentals
0996 = Patient convenience items-late discharge charge
0997 = Patient convenience items-admission kits
0998 = Patient convenience items-beauty shop/barber
0999 = Patient convenience items-other

NOTE: Following Revenue Codes reported
for NHCMQ (RUGS) demo claims effective
2/96.

9000 = RUGS-no MDS assessment available
9001 = Reduced physical functions-
       RUGS PA1/ADL index of 4-5
9002 = Reduced physical functions-
       RUGS PA2/ADL index of 4-5
9003 = Reduced physical functions-
       RUGS PB1/ADL index of 6-8
9004 = Reduced physical functions-
       RUGS PB2/ADL index of 6-8
9005 = Reduced physical functions-
       RUGS PC1/ADL index of 9-10
9006 = Reduced physical functions-
       RUGS PC2/ADL index of 9-10
9007 = Reduced physical functions-
```

```
         RUGS PD1/ADL index of 11-15
9008 = Reduced physical functions-
         RUGS PD2/ADL index of 11-15
9009 = Reduced physical functions-
         RUGS PE1/ADL index of 16-18
9010 = Reduced physical functions-
         RUGS PE2/ADL index of 16-18
9011 = Behavior only problems-
         RUGS BA1/ADL index of 4-5
9012 = Behavior only problems-
         RUGS BA2/ADL index of 4-5
9013 = Behavior only problems-
         RUGS BB1/ADL index of 6-10
9014 = Behavior only problems-
         RUGS BB2/ADL index of 6-10
9015 = Impaired cognition-
         RUGS IA1/ADL index of 4-5
9016 = Impaired cognition-
         RUGS IA2/ADL index of 4-5
9017 = Impaired cognition-
         RUGS IB1/ADL index of 6-10
9018 = Impaired cognition-
         RUGS IB2/ADL index of 6-10
9019 = Clinically complex-
         RUGS CA1/ADL index of 4-5
9020 = Clinically complex-
         RUGS CA2/ADL index of 4-5d
9021 = Clinically complex-
         RUGS CB1/ADL index of 6-10
9022 = Clinically complex-
         RUGS CB2/ADL index of 6-10d
9023 = Clinically complex-
         RUGS CC1/ADL index of 11-16
9024 = Clinically complex-
         RUGS CC2/ADL index of 11-16d
9025 = Clinically complex-
         RUGS CD1/ADL index of 17-18
9026 = Clinically complex-
         RUGS CD2/ADL index of 17-18d
9027 = Special care-
         RUGS SSA/ADL index of 7-13
9028 = Special care-
         RUGS SSB/ADL index of 14-16
9029 = Special care-
         RUGS SSC/ADL index of 17-18
9030 = Extensive services-
         RUGS SE1/1 procedure
9031 = Extensive services-
         RUGS SE2/2 procedures
9032 = Extensive services-
         RUGS SE3/3 procedures
9033 = Low rehabilitation-
         RUGS RLA/ADL index of 4-11
9034 = Low rehabilitation-
         RUGS RLB/ADL index of 12-18
9035 = Medium rehabilitation-
         RUGS RMA/ADL index of 4-7
```

```
                                9036 = Medium rehabilitation-
                                       RUGS RMB/ADL index of 8-15
                                9037 = Medium rehabilitation-
                                       RUGS RMC/ADL index of 16-18
                                9038 = High rehabilitation-
                                       RUGS RHA/ADL index of 4-7
                                9039 = High rehabilitation-
                                       RUGS RHB/ADL index of 8-11
                                9040 = High rehabilitation-
                                       RUGS RHC/ADL index of 12-14
                                9041 = High rehabilitation-
                                       RUGS RHD/ADL index of 15-18
                                9042 = Very high rehabilitation-
                                       RUGS RVA/ADL index of 4-7
                                9043 = Very high rehabilitation-
                                       RUGS RVB/ADL index of 8-13
                                9044 = Very high rehabilitation-
                                       RUGS RVC/ADL index of 14-18

                                ***Changes effective for providers entering***
                                **RUGS Demo Phase III as of 1/1/97 or later**

                                9019 = Clinically complex-
                                       RUGS CA1/ADL index of 11
                                9020 = Clinically complex-
                                       RUGS CA2/ADL index of 11D
                                9021 = Clinically complex-
                                       RUGS CB1/ADL index of 12-16
                                9022 = Clinically complex-
                                       RUGS CB2/ADL index of 12-16D
                                9023 = Clinically complex-
                                       RUGS CC1/ADL index of 17-18
                                9024 = Clinically complex-
                                       RUGS CC2/ADL index of 17-18D
                                9025 = Special care-
                                       RUGS SSA/ADL index of 14
                                9026 = Special care-
                                       RUGS SSB/ADL index of 15-16
                                9027 = Special care-
                                       RUGS SSC/ADL index of 17-18
                                9028 = Extensive services-
                                       RUGS SE1/ADL index 7-18/1 procedure
                                9029 = Extensive services-
                                       RUGS SE2/ADL index 7-18/2 procedures
                                9030 = Extensive services-
                                       RUGS SE3/ADL index 7-18/3 procedures
                                9031 = Low rehabilitation-
                                       RUGS RLA/ADL index of 4-13
                                9032 = Low rehabilitation-
                                       RUGS RLB/ADL index of 14-18
                                9033 = Medium rehabilitation-
                                       RUGS RMA/ADL index of 4-7
                                9034 = Medium rehabilitation-
                                       RUGS RMB/ADL index of 8-14
                                9035 = Medium rehabilitation-
```

```
                                    RUGS RMC/ADL index of 15-18
                          9036 = High rehabilitation-
                                    RUGS RHA/ADL index of 4-7
                          9037 = High rehabilitation-
1          REV_CNTR_TB                              Revenue Center Table
           -----------                             --------------------


                                    RUGS RHB/ADL index of 8-12
                          9038 = High rehabilitation-
                                    RUGS RHC/ADL index of 13-18
                          9039 = Very High rehabilitation-
                                    RUGS RVA/ADL index of 4-8
                          9040 = Very high rehabilitation-
                                    RUGS RVB/ADL index of 9-15
                          9041 = Very high rehabilitation-
                                    RUGS RVC/ADL index of 16
                          9042 = Very high rehabilitation-
                                    RUGS RUA/ADL index of 4-8
                          9043 = Very high rehabilitation-
                                    RUGS RUB/ADL index of 9-15
                          9044 = Ultra high rehabilitation-
                                    RUGS RUC/ADL index of 16-18
```